

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years, 1 month, 7 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 7 years, 1 month, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George
 City or town..... Bowie
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

Wilbur H. Anderson

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... ?
 7. Birth date of deceased (mo., day, yr.)..... 1880? 6.(c) If alive, give age..... years
 8. AGE: Years..... 66 Months..... ? Days..... ? If less than one day..... hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)
 10. Usual occupation..... Carpenter
 11. Industry or business..... Carpentering
 12. Name..... Randolph A. Anderson
 13. Birthplace..... ?
 14. Maiden name..... ? Hopkins
 15. Birthplace..... ?

16. Informant..... Hospital records
 Address..... Catonsville-28, Md.
 17. Burial Date thereof..... Feb 9th 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Perkins chapel
 Location..... Prince George Co.
 18. Funeral director..... Martin Fladung & Son
 Address..... Bowie Md.
 19. 2-7 46 Harold Miller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... February 6 19. 46 at 2:25 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 30 19. 38 to February 6 19. 46
 and that I last saw him alive on February 6 19. 46

Immediate cause of death.....
Nephritis, acute DURATION 5 days
Hyperstatic pneumonia 3 hours
 Due to..... Chronic glomerular nephritis Indef.
 Due to..... Myocardial insufficiency "
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results..... none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....
Daddy Funk
 23. SIGNATURE..... Isadora Tuerk, M.D. M. D. or other
 Address..... Catonsville-28, Md. Date signed 2/6/46

RECEIVED
FEB 11 1948
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

CERTIFICATE OF DEATH

Reg. Dist. No. 01299 38

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Hrs. 10 Minutes

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, MarylandHow long in hospital or institution? 9 Hrs. 10 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cuthy.City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 312 Dale Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME

OLIVER H. BAILEY

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Carolyn Bailey8. (c) If alive, give age 32 years7. Birth date of deceased (mo., day, yr.) 4-14-958. AGE: Years 50 Months 10 Days 1 If less than one day hrs. min.9. Birthplace Cove Point, Maryland
(Town, county, and state)10. Usual occupation Brick Layer

11. Industry or business

12. Name Basil Bailey13. Birthplace Maryland14. Maiden name Mamie Lake15. Birthplace Baltimore, Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland17. Burial Date thereof 2/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Parkville Md.18. Funeral director Wm. Cook Inc.Address St. Paul & Preston Sts., Balto., Md.19. 2/16/46 19. A. H. Hedrick
(Date by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1946, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 15, 1946, to February 15, 1946.and that I last saw him in alive on February 15, 1946.

Immediate cause of death

Bronchogenic Carcinoma left lung

DURATION

Unknown

Due to

Due to

Other conditions Broncho-pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Bronchogenic carcinoma left lung

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. BALTER, LT. COL., M.C. M. OLEN, DIR.Address Ft. Howard, Md. Date signed 2-15-46

FEB 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

01300

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 6810 Crossway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ella MayBaker.

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
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6.(b) Name of husband or wife Columbus W. Baker6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 28, 1876

8. AGE:	Years	Months	Days	if less than one day
	<u>69</u>	<u>2</u>	<u>3</u>	hrs. min.

8. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name	<u>George W. Fenton</u>
	<u>Va.</u>
13. Birthplace	

14. Maiden name	<u>Messick</u>
15. Birthplace	<u>Md.</u>

16. Informant Mr. David W. Baker
Address 4400 Towanda Ave.17. Transit Permit Date thereof 2/4/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Odd Fellows Cent.Location Seaford Del.18. Funeral director Wm. J. Tickner & SonsAddress Balto. Md.19. 2/3/46 19 Imparmine
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 19 46 at 12⁴⁵ P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov 15 19 45 to Feb 1 19 46
and that I last saw him alive on Jan 31 19 46

Immediate cause of death

Myocarditis, acute
hepatitis, acute
diabetes mellitus
terminal broncho-pneumonia, lobar

DURATION

5 yrs
6 mos

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Andrew M.D. M. D. or otherAddress 2 Kennedy St Date signed 2/2/46

CERTIFICATE OF DEATH

RECEIVED
FEB 8 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

39 Bloomsbury Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)Street No. 39 Bloomsbury Ave.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Linda Lee Ball

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single8. (b) Name of husband or wife None

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1942

8. AGE: Years Months Days If less than one day

3 6 9 hrs. min.9. Birthplace Union Memorial Hospital
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name Charles Edw. Ball13. Birthplace Catonville, Md.14. Maiden name Aileen Haver15. Birthplace Frederick, Md.16. Informant Charles Edward BallAddress 39 Bloomsbury Ave. Catonsville17. Burial Date thereof Feb. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn CemeteryLocation Woodlawn Balto. Co. Md.18. Funeral director Easton SonsAddress 608 Frederick Ave. Catonsville19. R-27 19 46 Harry G. Kiefer
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 25 - 1946 to Feb. 26, 1946and that I last saw her alive on Feb. 25, 1946Immediate cause of death Trachea - Tumor with Pulmonary EdemaDURATION 1 dayDue to Trachea - Tumor with Pulmonary EdemaDue to Trachea - Tumor with Pulmonary EdemaOther conditions Trachea - Tumor with Pulmonary Edema

(Include pregnancy within 8 months of death)

Major findings of operations Trachea - Tumor with Pulmonary EdemaDate of op. Feb. 26, 1946Autopsy results Trachea - Tumor with Pulmonary Edema

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Trachea - Tumor with Pulmonary Edema Date of Feb. 26, 1946Where did injury occur? Trachea - Tumor with Pulmonary Edema
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Trachea - Tumor with Pulmonary EdemaMeans of injury Trachea - Tumor with Pulmonary EdemaInjured at work? Trachea - Tumor with Pulmonary Edema23. SIGNATURE S. Lloyd JohnsonAddress Catonville, Md. Date signed 2-26-46

RECEIVED
MAR 1 1946
BUREAU V.N.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63a

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore Co.
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Interdenarian Nursing Home
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. "Famulelands"
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Elizabeth de Veaux Runyan Beale

3. (b) Social Security Number

4. Sex Female 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Geo. Blow Beale
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Apr 28, 1867
 8. AGE: Years 78 Months 10 Days 1 It less than one day _____ hrs. _____ min.

9. Birthplace Balto Co., Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Gustav W. Runyan, Jr.
 13. Birthplace Catonsville, Md.

MOTHER 14. Maiden name Eliz. Cassie Powell
 15. Birthplace Howard Co., Md.

16. Informant Win. Frances Runyan
 Address Catonsville, Md. 1946

17. Buried Date thereof Feb 25
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Green Mount
 Location Balto. Ind

18. Funeral director Berry N. Jenkins & Co
 Address Mc Culloch Orchard St

19. 2/25 19 46 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 19 46 at 9:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28 19 45 to Feb 22 19 46
 and that I last saw h. ex. alive on Feb 22 19 46

Immediate cause of death Cerebral Hem.
 DURATION 4 days

Due to arterio sclerosis
 DURATION 4 yrs.

Due to

Other conditions unilateral cerebral Hem. Nov 28, 1945
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Edward H. Jones
 M. D. or other _____
 Address 2004 Charles St Date signed 2/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County BaltimoreCity or town Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 302 Ridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Beelen

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Henry Beelen

7. Birth date of

deceased (mo., day, yr.)

Feb 11 1863

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

821126

hrs.

min.

9. Birthplace

Baltimore County

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

Conrad Milchling

13. Birthplace

Germany

MOTHER

14. Maiden name

Speeling

15. Birthplace

Unknown

16. Intermant

John H Seifert

Address

302 Ridge Road

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb 9 1946

(month) (day) (year)

Cemetery or crematory

St Peters Lutheran

Location

Fullerton

18. Funeral director

Lassahn Funeral Home

Address

7401 Belair Road

19.

Feb 8 1946
(Date rec'd by registrar)Mrs. G. L. Repert
Registrar

MEDICAL CERTIFICATION

Feb 6 19465.15 PM

20. DATE OF DEATH 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1 1946 to Feb 6 1946and that I last saw her alive on Feb 6 1946

Immediate cause of death

Coronary Thrombosis

DURATION

Sudden

Due to

Arterio-Sclerotic-Cerebrovascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

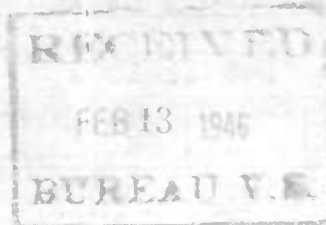
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Geo M. Baumgardner
M. D. or otherAddress Balto 6 Md Date signed 2-7-46

Dr Baumgardner
Phila Rd + Golden Ring



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01304

1. PLACE OF DEATH

County BaltimoreVillage or City Boring, Md.

No.

Registration Dist. No. 33

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

(a) Residence: No.

(Usual place of abode)

St.

Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)married5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofAmos H. Belt

6. DATE OF BIRTH (month, day, and year)

Jan 25 - 1881

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.65011

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Housewife9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.Housekeeping10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

FATHER

13. NAME

William C. Rawlings

14. BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

MOTHER

15. MAIDEN NAME

Margaret A. Miles

16. BIRTHPLACE (city or town)

(State or country)

Baltimore, Md.

17. INFORMANT

(Address)

Arthur Rawlings
Woodlandsburg, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place

Pleasant Grove

Date

Feb. 8, 1946

19. UNDERTAKER

(Address)

Edward C. Tipton
Hampstead, Md.

20. FILED

Feb 6, 1946Mary B. Eline

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February

(Month)

5

(Day)

1946

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

1940

to

Jan 30, 1946I last saw her alive on January 30, 1946; death is saidto have occurred on the date stated above, at 10:42 a.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Acute Coronary Thrombosis

Date of onset

Sudden(died suddenly)

Other Contributory Causes of importance:

Atherosclerosis
Hypertension280/240
110/902 yrs

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Cyril E. Finkle

M. D.

(Address) Upperco, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>8, 1940</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH: <u>Balto</u>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
County <u>Towson</u>				(For newborn infants give residence of mother)			
City or town <u>Towson</u>				State <u>md</u> County <u>Balto</u>			
(If outside city or town limits, write RURAL and give nearest town)				City or town <u>Towson</u>			
How long in above place of death? <u>late</u>				(If outside city or town limits, write RURAL and give nearest town)			
Hospital, institution, or street address where death occurred: <u>Prospect Hill po 7</u>				Street No. <u>Prospect Hill po 7</u>			
(If rural, give LOCATION)				2.(a) If veteran, name was			
3. (a) FULL NAME <u>George F. Bess.</u>				3. (b) Social Security Number			
4. Sex <u>M</u>				5. Color or race <u>W</u>			
6. (a) Single, married, widowed, or divorced <u>Married</u>				MEDICAL CERTIFICATION			
B. (b) Name of husband or wife <u>Bessie Bess</u>				2D. DATE OF DEATH <u>February 18</u> 19 <u>46</u> at <u>4:30 P.M.</u>			
7. Birth date of deceased (mo., day, yr.) <u>Nov. 3rd 1888</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 8</u> 19 <u>46</u> to <u>February 18</u> 19 <u>46</u>			
8. AGE: Years <u>57</u> Months <u>0</u> Days <u>0</u> If less than one day <u>hrs. min.</u>				and that I last saw <u>him</u> alive on <u>February 18</u> 19 <u>46</u> .			
9. Birthplace <u>Towson Md Balto co</u>				Immediate cause of death <u>Coronary Occlusion</u>			
(Town, county, and state)				Due to <u>arterio-sclerosis</u>			
10. Usual occupation <u>Laborer</u>				Due to <u>& hypertension</u>			
11. Industry or business				Other conditions			
12. Name <u>Benjamin Bess</u>				(Include pregnancy within 3 months of death)			
13. Birthplace <u>Towson Md.</u>				Major findings of operations			
14. Maiden name <u>Slaney?</u>				Date of op.			
15. Birthplace <u>Towson Md Balto co.</u>				Autopsy results			
16. Informant <u>Bessie Bess</u>				PHYSICIAN Please underline the cause to which death should be charged statistically.			
Address <u>713 Prospect Hill Towson Md</u>				22. VIOLENCE: If death was due to external causes, fill in the following:			
17. Burial <u>Pleasant Rest</u>				Accident, suicide, or homicide			
(Burial, cremation, or removal. Which?) <u>2-21-46</u>				Date of			
Cemetery or crematory <u>Towson Md Balto co.</u>				Where did injury occur?			
Location <u>Byronville and W. Wright</u>				(City or town) (County) (State)			
18. Funeral director <u>TD Pasquith St Balto-2-Md</u>				Injured at home, farm, industry, public place (where?)			
Address <u>713 Prospect Hill Towson Md</u>				Means of injury Injured at work?			
19. Date rec'd by registrar <u>Feb 21 1946</u>				23. SIGNATURE <u>Wm S. Green</u>			
Registrar <u>Wm S. Green</u>				M. D. or other			
				Address <u>Towson - Md</u> Date signed <u>2/19/46</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0130660
Reg. Dist. No.

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>12 yrs. 22 days</u> Hospital, institution, or street address where death occurred: <u>Spring Grove State Hospital</u> How long in hospital or institution? <u>12 yrs. 22 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>--</u> City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>109 Aisquith Street</u> (If rural, give LOCATION) 2. (a) If veteran, name war <u>--</u>											
3. (a) FULL NAME <u>Edwin J. Beveridge</u> (<u>Beaveridge</u>)				3. (b) Social Security Number <u>--</u>											
4. Sex <u>male</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>single</u>											
6. (b) Name of husband or wife <u>--</u>				6. (c) If alive, give age <u>--</u> years											
7. Birth date of deceased (mo., day, yr.) <u>December 11, 1879</u>				8. AGE: <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td><u>66</u></td> <td><u>1</u></td> <td><u>21</u></td> <td><u>--</u> hrs. <u>--</u> min.</td> </tr> </table>				Years	Months	Days	If less than one day	<u>66</u>	<u>1</u>	<u>21</u>	<u>--</u> hrs. <u>--</u> min.
Years	Months	Days	If less than one day												
<u>66</u>	<u>1</u>	<u>21</u>	<u>--</u> hrs. <u>--</u> min.												
9. Birthplace <u>Pennsylvania</u> (Town, county, and state)				10. Usual occupation <u>cook</u>											
11. Industry or business <u>odd jobs</u>				12. Name <u>Robert Beveridge</u> Beaveridge											
13. Birthplace <u>Pennsylvania</u>				14. Maiden name <u>Amanda Christie</u>											
15. Birthplace <u>Pennsylvania</u>				16. Informant <u>Hospital records</u> Address <u>Burial</u>											
17. (Burial, cremation, or removal, Which?) <u>Burial</u> Cemetery or crematory <u>Woodlawn</u> Location <u>Balto County, Maryland</u> 18. Funeral director <u>George L. Scherab</u> Address <u>2101 Frederick Avenue</u>				20. DATE OF DEATH <u>February 2</u> 19 <u>46</u> at <u>4:05 a</u> M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>January 10</u> 19 <u>34</u> to <u>Feb. 2</u> 19 <u>46</u> and that I last saw him alive on <u>February 1</u> 19 <u>46</u> Immediate cause of death <u>Chronic myocarditis</u> Other conditions <u>indef.</u> (Include pregnancy within 8 months of death) Major findings of operations <u>none</u> PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>none</u> Date of <u>--</u> Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury <u>None</u> Injured at work? <u>None</u>											
19. (Date rec'd by registrar) <u>2-4</u> 19 <u>46</u> <u>Armed</u> Registrar				23. SIGNATURE <u>Isadore Tuerk, M.D.</u> Address <u>Spring Grove Hospital, Catonsville, Md.</u> Date signed <u>2-2-46</u>											

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(181)

01307

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Baltimore
 City or town... Spaw Pt - 19 (Jones Run)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Virginia County...City or town... Roanoke
 (If outside city or town limits, write RURAL and give nearest town)Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

William Bobbitt

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced8.(b) Name of husband or wife... Grace Bollitt

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 19088. AGE: Years 37 Months 3 Days 25 If less than one day
hrs.min.9. Birthplace... Virginia
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER
 12. Name... Minnie William Bollitt
 13. Birthplace Va
 14. Maiden name... Minnie Cunningham
 15. Birthplace Va.

16. Informant... Wife

Address

17. Removal Date thereof... 2/26/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... UnknownLocation... Roanoke, Va.18. Funeral director... John G. ConnellyAddress... Essex, Md.19. 2/26 19. 46 John G. Connelly
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb. 15 19... 46 at... 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

DURATION

ShockDue to... 3rd degree burns of entire body

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of... 2-25-46Where did injury occur? Sp. Pt. Baylor Md
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury... Burned in apt. Bldg Injured at work? No23. SIGNATURE... John G. ConnellyAddress... Essex, Md. Date signed... 2/26/46

RECEIVED
MAR 9 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

01368

Reg. Dist. No.

1. PLACE OF DEATH:
 County Baltimore
 City or town Cowenton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Philadelphia Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Cowenton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Philadelphia Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME
Elsie B Bowers

3.(b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Andrew J Bowers

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 1895

8. AGE: Years 50 Months 6 Days 25 If less than one day hrs. min.

9. Birthplace Baltimore County
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Thomas A Biddison

13. Birthplace Baltimore Md

14. Maiden name Florence Earle

15. Birthplace Baltimore County

16. Informant Andrew J Bowers

Address Cowenton Md

17. Burial Date thereof 2/22/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Taylor Ave Baltimore

18. Funeral director Lessaier Funeral Home

Address 7401 Belair Road

19. Feb 20 19 46 W.M. Hemmott
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1946 6/15 AM 19 .. at .. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 45 to Feb 18 46
 and that I last saw him alive on Feb 18 46

Immediate cause of death

Carcinoma of Breast

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma

Date of op. 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? 0

23. SIGNATURE J. K. Insley

M. D. or other

Address 2936 F 301 Date signed 2-19-46

Dr Insley
2936 E V B alto

W 4863

RECEIVED
FEB 26 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 01309 40
 Reg. Dist. No.

1. PLACE OF DEATH:

 County Baltimore
 City or town Sweet Air Md
 (If outside city or town limits, write RURAL and give nearest town)

 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Wm. Benjamin Burk
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Singled

8. (b) Name of husband or wife

 7. Birth date of deceased (mo., day, yr.) Mch 4 1874 8. (c) If alive, give age _____ years

 8. AGE: Years 71 Months 11 Days 19 If less than one day _____ hrs. _____ min.

 9. Birthplace Baltimore County
 (Town, county, and state)
10. Usual occupation Truck farmer

11. Industry or business

12. Name John C. Burk13. Birthplace Germany14. Maiden name Lynde C Haman15. Birthplace Pennsylvania16. Informant George H BurkAddress Sweet Air Phoenix P.O. Md
 17. Burial Burial Date thereof 2/26/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St John Luth CemeteryLocation Sweet Air18. Funeral director Lewis Funeral HomeAddress 7401 Belair Road

19. (Date rec'd by registrar) _____

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Sweet Air Md
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. Paper Mill Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

Feb 23 1946 7.40 PM

20. DATE OF DEATH _____ 19 _____ at _____ M

 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 2, 1935 to Feb 23, 1946
 and that I last saw him alive on Feb 13, 1946
Immediate cause of death Coronary Thrombosis

DURATION

Coronary ScleroticHeart disease with 11 yrs.Hypertension

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Clifford F. Hudson, M.D.Address Fork, Md. Date signed 2/24/46

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
MAR 1 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

01310

31

Reg. Dist. No.

1. PLACE OF DEATH:

County... BaltimoreCity or town... Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5607 Windsor Mill Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... BaltimoreCity or town... Woodlawn
(If outside city or town limits, write RURAL and give nearest town)Street No. 5607 Windsor Mill Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ora V. Cameron

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... George W. Cameron

7. Birth date of

deceased (mo., day, yr.)

November 5, 18816. (c) If alive, give age... 74 years

8. AGE:

Years

Months

Days

If less than one day

64223

hrs.

min.

9. Birthplace

Carroll County, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

FATHER

12. Name

James N. Fox

13. Birthplace

Carroll County, Md.

MOTHER

14. Maiden name

Sarah M. Sharrer

15. Birthplace

Carroll County, Md.

16. Informant

Mr. George W. Cameron

Address

5607 Windsor Mill Rd., Woodlawn

17.

Burial

Date thereof

Mar. 2, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Lorraine Cemetery

Location

Woodlawn, Md.

18. Federal director

Address

4510 Liberty Heights Ave.

19.

March 3, 1946A. W. Hedrich

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH... February 28 1946, at 755 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

N.Y. 1945, to Feb 28 1946
and that I last saw him/her alive on Feb 28 1946

Immediate cause of death

Acute Wilekemia + Myocardial Failure (Old German Army)

Due to

Due to

Other conditions

Acute Pulmonary Edema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thor T. Abbott M. D. or otherAddress 4509 Liberty Hgts Ave. Date signed

DURATION

1 hr(3 mos)1 hr

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 13-6

Reg. Dist. No. 33

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Maryland
 (b) City or town Reisterstown, Md
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution: Mt Pleasant Sanatorium
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 5-3-1939
 (e) Length of stay in this community (yrs., mos., or days) 40 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County _____
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 2036 Brookfield Ave
 (If rural give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

Jonas Caplan

3 (b) If veteran, name war

3 (c) Social Security No. _____

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

Rose

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 14, 1871

8. AGE:

Years

Months

Days

If less than one day

74

1

21

hr.

min.

9. Birthplace

Chernizov, Russia
 (town, county, and state)

10. Usual occupation

Painter

11. Industry or business

MOTHER FATHER

12. Name

Wolf Caplan

13. Birthplace

Russia

14. Maiden Name

FREIDA PEUZNER

15. Birthplace

Russia

16 (a) Informant

Carl Caplan

(b) Address

3704 W Garrison Ave

17 (a)

Burial

(b) Date thereof

2-6-46

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

Rosedale

18 (a) Funeral director

Jack Lewis Inc

(b) Address

477 E. Baltimore St

19 (a)

2-6-46

(b)

Wurkebach

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. Date of death February 5, 1946 at 5 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3, 1939, to February 5, 1946, and that I last saw him alive on Feb 5, 1946.

Immediate cause of death

Pulmonary Tuberculosis

Duration

Due to

Myocardial Collapse

20 years

Due to

Other conditions

Coronary Thrombosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature Albert F. Shriver M.D.

M. D. or other

Address 6118 Park Heights Ave Date signed _____

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Be

01312

Reg. Dist. No.

44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, MarylandHow long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1617 McCullough Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I ✓

3. (a) FULL NAME

THOMAS H. CARDWELL

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	------------------------------------	--

6. (b) Name of husband or wife Mary Cardwell6. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) 5-10-88

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>8</u>	<u>21</u>	hrs. min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Peter Cardwell13. Birthplace Virginia14. Maiden name Hannah Carey15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland17. Burial Date thereof 2-6-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory National CemeteryLocation Hindman Rd. Balt. Ind18. Funeral director Graves & SonsAddress 1735 Kenilworth Ave - 1719. 2/5/46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 1, 1946 at 12:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 28, 1946 to February 1, 1946and that I last saw him alive on February 1, 1946

Immediate cause of death

Nephritis, Parenchymatous chronic

DURATION

4 Mos.

plus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNED A. M. BALTER, LT. COL., M.C. CLIN. DIR.Address Fort Howard, Maryland Date signed 2-1-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St. Baltimore
CERTIFICATE OF DEATH 1640

Registered No. 17

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Texas
- (c) Hospital or institution: Balto. Co. Md.
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County Baltimore
- (c) City or town Texas
(If outside city or town limits, write RURAL and give town)
- (d) Street No. (If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Benjamin F. Chaffman, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar. 31, 1917

8. AGE: Years Months Days

28

10

18

If less than one day

hr.

min.

9. Birthplace

Allegheny Co. Md.
(Town, county, and state)

10. Usual Occupation

Machinist

11. Industry or business

Black & Decker Co.

12. Name

Ben F. Chaffman, Sr.

13. Birthplace

Balto. Co. Md.

14. Maiden Name

Aelia Marole

15. Birthplace

Culpepper, Va.

16 (a) Informant

Russell M. Chaffman

(b) Address

Sgt. a - Maxwell Field, Md.

17 (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

Feb 27, 1946
(month) (day) (year)

(c) Cemetery or crematory

Poplar

Location

Coolidgeville, Md.

18 (a) Funeral director

Linden M. Bush

(b) Address

Sparks, Md.

19 (a)

2-26

(b)

46 Wilmer C. Ensor

(Date recd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-21-1946 at P. M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☐, suicide ☒,

homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2-19-46 at P. M.

(b) Where did injury occur? Texas, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Rifle bullet wound of head.

23. Signature Thomas J. Unice M.D.

Date signed 2-25-46 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH 166

Registered No. 01

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-21-

1946, at

P.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☐, suicide ☐,

homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bullet wounds of brain and spine cord

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-19? at P.M.

(b) Where did injury occur? Texas, Ind.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Rifle wound of head

23. Signature H. J. Wallace M.D.

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01316

Reg. Diat. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Crofton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Crofton
(If outside city or town limits, write RURAL and give nearest town)Street No. 605 Edmonson Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles E. Cole

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary E7. Birth date of deceased (mo., day, yr.) Aug 28 18738. AGE: Years 42 Months 5 Days 7 If less than one day
..... hrs. min.9. Birthplace Baltimore MD
(Town, county, and state)10. Usual occupation Hotel Clerk Retired11. Industry or business Hotel Clerk12. Name William E. Cole13. Birthplace MD14. Maiden name Williamina Cromble15. Birthplace MD16. Informant William E. ColeAddress 605 Edmonson Rd17. Crofton Date thereof 2/8/46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory CroftonLocation Crofton18. Funeral director William E. ColeAddress 1217 4th St19. 2-6 19 46

(Date rec'd by registrar)

Registrar W. E. Cole

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 19 46 at 1:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 5 19 36 to Feb 5 19 46and that I last saw him alive on Feb 5 19 46

Immediate cause of death

Cerebral Stomach2. Intestinal

Due to

cholesterol

Due to

cholesterol

Other conditions

10 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. E. ColeAddress 5407 Belvoir RdDate signed 2-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 187

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore
 City or town Bundalk 22, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mo
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balto. Co.
 City or town Bundalk 22, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 103 Pauliski Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Jean Louise Coleman

3.(b) Social Security Number

4. Sex Female 5. Color or race Infant 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1946 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 22, 1946 to February 22, 1946

and that I last saw him/her alive on death certificate 19

Immediate cause of death Bronchial pneumonia

DURATION

2 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Kade, M.D.

M. D. or other

Address 140 Oak Ave Date signed 2-22-46

FEB 23 1946

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Baltimore
Village or City Davisville

Registration Dist. No. 33

No. 86 St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ellis Mrs Kinley Cornett

(a) Residence: No. St. Ward.
(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Oct 26 - 1945

7. AGE Years Months 4 Days 2 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
10. Data deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town). Smith Co. Va
(State or country)

FATHER 13. NAME Ellis Mrs Kinley Cornett
14. BIRTHPLACE (city or town). Petersburg, Va
(State or country)

MOTHER 15. MAIDEN NAME Mildred Marie Roark
16. BIRTHPLACE (city or town). Smith Co. Va
(State or country)

17. INFORMANT Mildred Marie Cornett
(Address) Cockeysville, Md, R.F.D.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Zion Date March 1, 1946

19. UNDERTAKER J. F. Klein Sons
(Address) Parkton Md.

20. FILED 3 - 1, 1946 MARY B. ELIOT
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February 28, 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1946, to Feb 28, 1946.

I last saw him dead on Feb. 28, 1946; death is said to have occurred on the date stated above, at 8:05 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Presumably Cramps with Convulsions

Date of onset

Feb 28-46

Other Contributory Causes of importance:

Marasmus

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Dezire E. Fowble M. D.

(Address) Upperco Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **01319**

1. PLACE OF DEATH: **C**
 (a) Baltimore **City**, Maryland
 (b) Street address **129 Oaklee Village**
 (c) Hospital or institution: *********
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *********
 (e) Length of stay in Baltimore (yrs., mos., or days) **Lffe**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Maryland** (b) County.....
 (c) City or town **Baltimore Md.**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **129 Oaklee Village**
 (If rural give location)
 (e) Citizen of foreign country?.....(Yes or No)
 If yes, name country.....

3 (a) FULL NAME **JOHN H. DAMES**
 3 (b) If veteran, name war..... 3 (c) Social Security Account No.....
 4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Married**
 6 (b) Name of husband or wife **Gertrude E. Dames**
 6 (c) If alive, give age **70** years
 7. Birth date of deceased (mo., day, yr.) **Jan. 26, 1873**
 8. AGE: Years **73** Months **-** Days **20** If less than one day ********* hr. min.
 9. Birthplace **Baltimore Maryland**
 (Town, county, and state)
 10. Usual Occupation **Bookkeeper**
 11. Industry or business **Fulton Laundry**

FATHER 12. Name **John Dames**
 13. Birthplace **Maryland**
 MOTHER 14. Maiden Name **Hannah Geisendorfer**
 15. Birthplace **Maryland**
 16 (a) Informant **Mrs. Gertrude E. Dames**
 (b) Address **129 Oaklee Village**
 17 (a) **Burial** (b) Date thereof **2/19/46**
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory **Loudon Park Cemetery**
 Location **3801 Frederick Ave. City**
 18 (a) Funeral Director **Chapman & Son**
 (b) Address **1300 Eutaw Place.**
 19 (a) **Feb 19 1946** (b) **William H. Williams**
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION
 20. DATE OF DEATH **February 15, 1946**, at **12:20** M
 21. I certify that death occurred on the date above stated; that I attended deceased from **Feb 1** 1946, to **Feb 15** 1946 and that I last saw him alive on **Feb 14** 1946.

Immediate cause of death **Diabetes Mellitus.**
 Due to **old age**
 Due to **Exhaustion.**
 Other Conditions.....
 (Include pregnancy within 3 months of death)
 Date of operation.....
 Major findings of operation:.....
 of autopsy: **No.**
 22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide.....
 (b) Date of occurrence..... at..... M
 (c) Where did injury occur?..... (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?
 (Specify type of place)
 (e) Means of injury **In bed C. Blake**
 23. Signature **Dr. Herbert C. Blake** M. D.
 Address **Medical Arts Bldg.** Date signed.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

FEB 23 1940

BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

usual residence of deceased

is John BowersFILM No. 100 FEB 18 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 01220 30

1. PLACE OF DEATH:

County 208 Bloomsbury Ave CatonsvilleCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 208 Bloomsbury Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

James Wilson Deibel

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Harriet E. Deibel7. Birth date of deceased (mo., day, yr.) Nov. 6 - 18626. (c) If alive, give age 83 years

8. AGE:

Years

Months

Days

If less than one day

8331

hrs.

min.

9. Birthplace

Baltimore Ind.
(Town, county, and state)

10. Usual occupation

Retired Railroad Man

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Germany

MOTHER

14. Maiden name

Unknown

15. Birthplace

Germany

16. Informant

Mrs. D. W. Osborn

Address

2746 Winchester Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 11 - 1946
(month) (day) (year)

Cemetery or crematory

Linden Park Cem.

Location

Balto. Ind.

18. Funeral director

Manice Cook Super

Address

1600 W. North Ave.

19.

(Date rec'd by registrar)

19.

2/11 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1946, at 2:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1940, to February 7, 1946, and that I last saw him alive on Feb. 6 1946

Immediate cause of death

Pulmonary Edema

DURATION

2 Days

Due to

arterio sclerosis

Due to

myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. Osborn

M. D. or other

Address 208 Bloomsbury Ave Date signed 2/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

01321

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
City or town Crofters Stoneleigh
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution: 710 Stoneleigh Ave
Stay in hospital or inst. (yrs., or mos., or days) 8 yr 2 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Va. County Napolek
City or town Portsmouth Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 700 West Hollands Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Mary Campbell Young De Murguiondo

3. (b) Social Security Number

4. Sex f. 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Victor De Murguiondo
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Aug 9 - 1863

8. AGE: Years 82 Months 7 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Petersburg Va
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Thomas T. Young
13. Birthplace Petersburg Va

14. Maiden name Mary Bell
15. Birthplace Petersburg Va

16. Informant Mrs. Lobes De Murguiondo Connell
Address 710 Stoneleigh Rd

17. Buried Date thereof Feb 22, 1946
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Greenmount
Location Beth. Pl.

18. Funeral director John Burns Sons
Address 610 York Rd

19. Feb 22 19 46
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20- 19 46 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-17- 19 46 to 2-20- 19 46
and that I last saw him alive on 2-20-46 19

Immediate cause of death Subarachnoid hemorrhage
Due to arteriosclerosis

Due to _____
Other conditions Pr. Pneumonia

(Include pregnancy within 3 months of death)
Major findings:
Of operations _____

Of autopsy _____
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Victor Richards MD M. D. or other
Address 321 Dunkirk Rd Date signed 2-20-46

DURATION

3 days
15 yrs.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 1 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

Reg. Dist. No. 01322 30

1. PLACE OF DEATH:

County... BaltoCity or town... Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 yrs.

Hospital, institution, or street address where death occurred:

Edmondson & HumphreysHow long in hospital or institution? 11 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... BaltoCity or town... Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No... Edmondson Ave
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Margaret Dietel

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Jacob Dietel

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) April 18th 18508. AGE: Years 95 Months 9 Days 17 If less than one day
hrs. min.9. Birthplace... Germany
(Town, county, and state)10. Usual occupation... at home

11. Industry or business

12. Name Johanna Bauer13. Birthplace Germany14. Maiden name Eva15. Birthplace Germany16. Informant Miss Margaret MuthAddress 411 N. Cedar Ave17. Buried Date thereof 2 6 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BaltimoreLocation Balto. Md.18. Funeral director Funeral HomeAddress 7401 Belair Ave19. 2-6- 46 Harriet Miller
(Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 4th 19... 46 at... 7 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 39 to Feb 4 46 and that I last saw him alive on Feb 4 46Immediate cause of death Chr Myocarditis

DURATION

1 monDue to Generalized ArterioSclerosisDue to Generalized ArterioSclerosisDue to Generalized ArterioSclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. HouchensAddress Catonsville Date signed 2-4

M. D. or other

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. NAME OF DECEASED

DATE OF DEATH

RECEIVED
FEB 14 1946
BUREAU V S.

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. SIGNATURE OF PHYSICIAN

6. SIGNATURE OF REGISTRAR

7. SIGNATURE OF WITNESSES

8. SIGNATURE OF DECEASED

9. SIGNATURE OF NEXT OF KIN

10. SIGNATURE OF CLERGYMAN

11. SIGNATURE OF JUDGE

12. SIGNATURE OF SHERIFF

13. SIGNATURE OF CORONER

14. SIGNATURE OF DISTRICT ATTORNEY

15. SIGNATURE OF COUNTY CLERK

16. SIGNATURE OF TOWN CLERK

17. SIGNATURE OF VOTING CLERK

18. SIGNATURE OF POLL CLERK

19. SIGNATURE OF TELLER

20. SIGNATURE OF CLERK

21. SIGNATURE OF DEPUTY CLERK

22. SIGNATURE OF ASSISTANT CLERK

23. SIGNATURE OF CLERK

24. SIGNATURE OF DEPUTY CLERK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-2)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 113 20 Park Lane
(If rural, give LOCATION)2.(a) If veteran, name war N

3. (a) FULL NAME

Mollie Donaghy

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

W.6. (b) Name of husband or wife Robert J.

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 - 18808. AGE: Years 65 Months 7 Days 3 If less than one day hrs. min.8. Birthplace Ireland
(Town, county, and state)10. Usual occupation Retired night supervisor11. Industry or business McKend Hospital12. Name Edward Rodgers13. Birthplace Ireland14. Maiden name Cecelia McNulty15. Birthplace Ireland16. Informant Lillian DonaghyAddress 3637 Greenmount Ave17. Burial Date thereof 2/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Moeland Memorial ParkLocation Parkville18. Funeral director Wm Cook Inc.Address 1217 St Paul St.19. 2-12-46 Quellendy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 - 46 19 46 at 2 50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Feb. 19 46 to 10 Feb. 19 46
and that I last saw ER alive on 9 Feb. 19 46Immediate cause of death Uremia

DURATION

2 yrsDue to Hypertension - Cardiovascular-renal diseaseDue to 2 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lloyd E. Saylor M.D.
M. D. or otherAddress 3902 Greenmount Ave Date signed 10 Feb. '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (834)

CERTIFICATE OF DEATH

Reg. Diat. No. 01324 33

1. PLACE OF DEATH:

County Balto.
 City or town Glyndon
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 42 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Glyndon
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Central Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3.(a) FULL NAME

Charles F. Eckhardt

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

B.(b) Name of husband or wife

Myrtle W. Eckhardt

7. Birth date of

deceased (mo., day, yr.)

March 9, 1871

B.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

74

11

2

hrs.

min.

9. Birthplace

Balto. Co.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Western Maryland Railway

FATHER

12. Name

Conrad Eckhardt

13. Birthplace

Germany

MOTHER

14. Maiden name

Mary S. Ginter

15. Birthplace

Germany

16. Informant

Glyndon Eckhardt

Address

Glyndon, Md.

17.

(Burial, cremation, or removal. Which?)

Cemetary or crematory Luthern CemeteryLocation Reisterstown, Md.

18. Funeral director

J.F. Eline & Sons

Address

Reisterstown, Md.

19.

2-13-46
(Date rec'd by registrar)19 46Mary B. Eline
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 1119 46, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-2319 46, to2-1119 46

and that I last saw him alive on

2-1019 46

Immediate cause of death

Cerebral Vascular Occlusion

DURATION

3 days

Due to

arteriosclerosis3 yrs

Due to

Other conditions Hernia - Inguinal3 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. D. Caplan, M.D.

M. D. or other

Address

Reisterstown, Md.Date signed 2-13-46

FEB 16 1946

FEB 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01325

Reg. Dist. No. 44

1. PLACE OF DEATH
County Baltimore - 19-
City or town Sparks Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 months
Hospital, institution, or street address where death occurred:
Box 252 Rt 10 - Millersville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State As in #1 County 1
City or town As in #1
(If outside city or town limits, write RURAL and give nearest town)
Street No. As in #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Eder

3. (b) Social Security Number

NONE

4. Sex Male 5. Color of race white 6. (a) Single, married, widowed, or divorced Widower
6. (b) Name of husband or wife Elizabeth Eder
6. (c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) Feb. 1852 (Way unknown)

8. AGE: 94 Years Months Days If less than one day
hrs. min.

9. Birthplace Russo-Poland
(Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business Truck farming

12. Name Unknown

13. Birthplace "

14. Maiden name "

15. Birthplace "

16. Informant Mrs. Amelia Erdman - daughter

Address Willow Ave. Ex. 252A. SP. Pt.,

17. Burial Date thereof 3/4/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory OAK LAWN CEMETERY

Location BALTIMORE? MARYLAND

18. Funeral director HENRY SANDER & SONS, INC.

Address NORTH AVE. & BROADWAY

19. March 4 19 46 Amelia Erdman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 19 46 at 2:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 19 43 to Feb 28 19 46.

and that I last saw him alive on Feb. 28, 1946 in Way unknown

Immediate cause of death

Senility

Due to arteriosclerosis 20 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ronald Gallie M.D.

Address Sparks Pt. Md. Date signed 2/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01326

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 0 mos., 12 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution? 0 yrs., 0 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1305 Rayleigh Way, O'Donnell Hgts
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Blanche Edmonds

3. (b) Social Security Number

236-26-7301

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Mr. Pearle Edmonds
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 16, 1900
 8. AGE: Years 45 Months 10 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Summers Co., West Virginia
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Robert F. Beasley
 13. Birthplace Massachusetts
 14. Maiden name Ella Willey
 15. Birthplace Massachusetts

16. Informant Mrs. Blanche Edmonds
 Address 1305 Rayleigh Way, O'Donnell Hgts
Balto., Md.

17. Burial Feb. 9, 1946
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Hilltop Cemetery
 Location Hilton, West Virginia

18. Funeral director Frank H. Newell
 Address Pikesville, Maryland

19. Feb. 6, 1946 Earl T. Webster
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1946, 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25, 1946, to Feb. 6, 1946, and that I last saw her alive on February 6, 1946.

Immediate cause of death Pulmonary Tuberculosis

DURATION
5 Yrs.
6 Mos.

Due to Tubercle Bacilli

Due to _____

Other conditions Fatal Pulmonary Hemorrhage
 (Include pregnancy within 8 months of death)

Major findings of operations No operation

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D.

Address Mount Wilson, Md. Date signed 2/6/46

Rec'd - 2-9-46

Dr. S. E. Michael

RECEIVED

FEB 11 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01327

Reg. Dist. No. 44

1. PLACE OF DEATH:
 County Baltimore
 City or town Middle River
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Edwards Lane
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Middle River
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Edwards Lane
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Mildred E Edwards
 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife George A Edwards
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct 21 1877
 8. AGE: Years 68 Months 4 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Howard County, Md.
 (Town, county, and state)
 10. Usual occupation At Home
 11. Industry or business
 12. Name Samuel E Feltz
 13. Birthplace Maryland
 14. Maiden name Mary Wilson
 15. Birthplace Maryland

16. Informant Capt. George A Edwards
 Address Edwards Lane Middle River Md
 17. Burial Date thereof 3/2/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Orem Cemetery
Middle River
 Location Lassahn Funeral Home
 18. Funeral director Lassahn Funeral Home
 Address 7401 Belair Road
 19. 3-1- 19 46 John J Connelley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2/27/46 12.30 PM

20. DATE OF DEATH 19_____, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 10 19_____, to Feb 22 19_____,
 and that I last saw him alive on Feb 26 19_____.
 Immediate cause of death _____

Other conditions Secondary anemia
 (Include pregnancy within 8 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W Lee Shickel M.D. or other
 Address 411C North Portman Date signed 2/27/46

DURATION

5 days

5 months

CERTIFICATE OF DEATH

RECEIVED
MAR 4 1946
BUREAU T. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Dist. No. 01328 42

1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Patrick Enright7. Birth date of deceased (mo., day, yr.) Jan. 12 1946 18626. (c) If alive, give age years8. AGE: Years 84 Months 1 Days 12 If less than one day hrs. min.9. Birthplace Ohio
(Town, county, and state)10. Usual occupation None11. Industry or business Edward Reiter12. Name Edward Reiter13. Birthplace Ohio14. Maiden name Unknown15. Birthplace Ohio18. Informant Mrs. W.E. BuesAddress Dogwood Rd. Woodlawn Sub.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 20 1946
(month) (day) (year)Cemetery or crematory Green Lawn CemeteryLocation Columbus, Ohio18. Funeral director E. Willis LamoranAddress 4510 Liberty Heights Ave.19. Feb 17 1946 Registrar Sheffer

(Date recorded by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)Street No. Dogwood Road
(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1946 at 9:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

DURATION

Due to Acute cardiac failureDue to Cardiovascular diseaseOther conditions sudden death

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

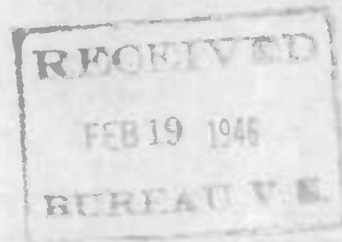
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Willis Lamoran M. D. or otherAddress 1010 Hudson Date signed 2-17-46



*Mark
Ken*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01329

CERTIFICATE OF DEATH

★ Reg. Dist. No. 30

1. PLACE OF DEATH

County Baltimore Co.City or town Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 mo.

Hospital, institution, or street address where death occurred:

122 Forest Drive.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 122 Forest Drive
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Anna T. Essig.

3. (b) Social Security Number

4. Sex F5. Color or race w

6.(a) Single, married, widowed, or divorced

widowed.6.(b) Name of husband or wife Chas Essig.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1877.

8. AGE: Years Months Days If less than one day

68 hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Domestic11. Industry or business House work12. Name August Robert13. Birthplace Germany14. Maiden name Johanne Gestelfort15. Birthplace Germany16. Informant Charles Essig.Address 122 Forest Drive17. Burial Date thereof 3/2/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Graceland ParkLocation Bae & City Md.18. Funeral director Edw J Mac NabbAddress Catonsville Md.19. 3-2 19 46 Darryl K Miller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 19 46 at 7:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 16 19 46 to Feb. 27 19 46and that I last saw him alive on Feb. 27 19 46

Immediate cause of death

Peripheral vascular cell apse DURATION 30 minsDue to Acute myocardial infarction 30 minsDue to Arteriosclerotic cardio-vascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

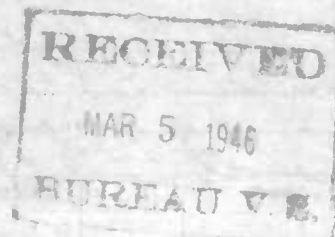
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Z. Bowers M. D. or otherAddress 26 Munnay Lane Date signed Mar 1 1946

26 - My Lane



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

CERTIFICATE OF DEATH

Reg. Dist. No. 01330 44

1. PLACE OF DEATH:

County BALTIMORECity or town EDGEMERE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 YEARS

Hospital, institution, or street address where death occurred:

2822 WELLS AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORECity or town EDGEMERE SPARROWS POINT
(If outside city or town limits, write RURAL and give nearest town)Street No. 2822 WELLS AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ELMER ELLSWORTH EWING SR.

3. (b) Social Security Number

316-10-1316

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife MARY CATHERINE

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) JULY 11, 18838. AGE: Years 62 Months 6 Days 26 If less than one day9. Birthplace STREETS HANOVER CO. MD.
(Town, county, and state)10. Usual occupation STEEL WORKER11. Industry or business BETHLEHEM STEEL CO.12. Name JOHN A EWING13. Birthplace ?14. Maiden name JOSEPHINE ADAMS15. Birthplace ?16. Informant JOHN A EWINGAddress 2822 WELLS AVE, EDGEMERE17. BORIAL Date thereof Feb 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MORELAND MEMORIAL PARKLocation TAYLOR AVE, BALTO. CO.18. Funeral director WILLIAM COOK, INC.Address 1217 ST. PAUL ST19. Feb 6 - 46 Dawson T. Harbes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1946, at 29 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to Feb 6 - 1946and that I last saw him alive on February 5 - 1946Immediate cause of death Lobiose Bronchial Asthmaand Emphysema withinfectious pleurisyDue to Pulmonary Edema

Due to

Other conditions Myocardial degeneration

.....

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dawson T. HarbesSparrows Point 19 md M. D. or other

Address

RECEIVED

FEB 8 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01331 44
Reg. Dist. No.

1. PLACE OF DEATH:

County Balto.
City or town Sparrows Pt.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Balto.
City or town Sparrows Point Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 813 C St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

JESSAMINE FEE

3. (b) Social Security Number

no

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Seth H. Fee
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1869
8. AGE: Years 76 Months 5 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Netawake, Kansas
(Town, county, and state)
10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William B. Roberts
13. Birthplace U. S. A.
MOTHER 14. Maiden name Austa Early
15. Birthplace Ill.

18. Informant Mrs. C. A. Waite
Address 813 C Street, Sparrows Pt., Md. (19)

17. Removal 2/11/46
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Prospect Hill Cem.
Location Harrisburg, Pa.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. Feb 11 - 1946 Dwight F. Harder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9, 1946, at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1945 to Feb 9, 1946
and that I last saw him alive on February 8, 1946

Immediate cause of death the Congestive Heart Failure
Due to Myocardial Extension - Arteriosclerosis - cardiovascular disease
Disease

DURATION

8 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. Wm. J. Tickner M.D.
Address 520 D St. Balt. Md. Date signed 2-9-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 13 1946

BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

20-23-46

Sherrill Miller

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/20 1946, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1946, to Feb. 20 1946, and that I last saw him alive on Feb. 20 1946.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

William H. Gallagher

M. D.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82-2

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No..... 616 Orpington Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

ADDIE C. FISCHBACH

3.(b) Social Security Number

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife..... HENRY G. FISCHBACH

7. Birth date of deceased (mo., day, yr.)..... FEBRUARY 6 1887

8. AGE: Years Months Days If less than one day
59 -- 12 ***** hrs. min.8. Birthplace..... Baltimore Maryland
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... At Home

12. Name..... Frederick Bohne

13. Birthplace..... Germany

14. Maiden name..... Laura Schlifer

15. Birthplace..... Maryland

16. Informant..... Mr. Henry G. Fischbach

Address..... 616 Orpington Road

17. Burial Date thereof..... Feb. 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Loudon Park Cemetery

Location..... 3801 Frederick Ave. City

18. Funeral director..... Dr. B. Hippert & Son

Address..... 1300 Eutaw Place

19. Feb 21 19 46 (Date rec'd by registrar)

Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... FEBRUARY 18 46 5:15P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb 11 19 46 to Feb 18 19 46
and that I last saw her alive on Feb 18 19 46

Immediate cause of death..... Cerebral Hemorrhage

DURATION

7 days

Due to..... Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Harry Glassman

M. D. or other..... Dr. Harry Glassman

Address..... 735 West Fayette St. Date signed..... 27/146

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Adm Co. Baltimore countyCity or town Rosemont 2856 Maryland Ave
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Adm Co. Balto co.City or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)Street No. 2856 Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Fitzgerald

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Walter Fitzgerald

7. Birth date of

deceased (mo., day, yr.)

November 11, 18806.(c) If alive, give age 75 years

8. AGE:

65

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Alexander Myers

13. Birthplace

Maryland

MOTHER

14. Maiden name

Rebecca Personette

15. Birthplace

Maryland

16. Informant

Mr. Walter Fitzgerald

Address

2856 Maryland Ave, Rosemont, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/14/46
(month) (day) (year)

Cemetery or crematory

Landon Park

Location

Friedrich Ave

18. Funeral director

John F. Denny Inc

Address

714 Light St.

19.

7/13/46
(Date rec'd by registrar)46Quintessence
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11th 1946, at 1³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 20 1946, to February 10 1946
and that I last saw her alive on February 10 1946

Immediate cause of death

Acute Pulmonary Edema

DURATION

Due to

Hypertensive Cardiac -
Vascular Disease

Due to

Other conditions

Bronchial Asthma

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Morris W. Stember
M. D. or other

Address

410 N. Hilton

Date signed

Feb 13, 46

Steinberger

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

01335

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
 County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants, give residence of mother)
 State Maryland County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2 Dreher Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME Amos Ursula Fox

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Elizabeth R. Fox
 7. Birth date of deceased (mo., day, yr.) April 17, 1892 6. (c) If alive, give age _____ years
 8. AGE: Years 53 Months 10 Days 10 It less than one day _____ hrs. _____ min.

9. Birthplace Balto. Co. Md.
 (Town, county, and state)
 10. Usual occupation Retired Streetcar operator
 11. Industry or business Balto. Transit Co
 12. Name George Fox
 13. Birthplace Balto. Co. Maryland.
 14. Maiden name Elizabeth Smith
 15. Birthplace Baltimore Co. Maryland.

16. Informant Verley Fox
 Address 2 Dreher Ave. Pikesville, Md.
 17. Burial Date thereof March 2, 46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Thomas
 Location Garrison, Forest
 18. Funeral director Frank H. Newell
 Address Pikesville, Maryland
 19. 3-1- 19 46 Dr. E. E. Nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 19 46 at 5 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 - 19 46, to Feb 27 19 46,
 and that I last saw him alive on Feb 27 - 19 46
 Immediate cause of death Coronary Artery disease DURATION 16 days
 Due to Atherosclerosis ?
 Due to _____ ?
 Other conditions Diabetes mellitus ?
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE E. E. Nichols M.D. M. D. or other
 Address Pikesville, Md. Date signed Feb 1 - 46

RECEIVED BY CENTRAL STATE CHAIRMAN

RECEIVED BY CENTRAL STATE CHAIRMAN

RECEIVED

MAR 2 1946

BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 41336

CERTIFICATE OF DEATH

1. PLACE OF DEATH: **Baltimore**
 (a) County _____
 (b) City or town **Essex**
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution: **504 Mace Ave**
 (d) Length of stay in hospital or inst. (yrs., mos., or days) _____
 (e) Length of stay in this community (yrs., mos., or days) _____

2. HOME (USUAL RESIDENCE) OF DECEASED:
Maryland (b) County **Baltimore**
 (a) State _____
 (c) City or town **Essex**
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. **504 Mace Ave**
 (If rural give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

3 (a) FULL NAME **Lillian Louisa Frank.**

3 (b) If veteran, name war **No** 3 (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Widowed**

6 (b) Name of husband or wife **John J. Frank**
 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) **June 19 1897**

8. AGE: Years **49** Months **8** Days **4** If less than one day _____ hr. _____ min.

9. Birthplace **Baltimore County**
 (Town, county, and state)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Henry Norris**

13. Birthplace **Baltimore City Md**

14. Maiden Name **Emma Brehm**

15. Birthplace **Baltimore City Md**

16 (a) Informant **Mrs Earl Johnson**

(b) Address **504 Mace Ave**

17 (a) **Burial** (b) Date thereof **2/27/46**
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Oak Lawn**
 Location **Eastern Ave**

18 (a) Funeral director **Lazarus Funeral Home**

(b) Address **7401 Belair Road**

19 (a) **2/27/46** (b) **John S. Brumley**
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. Date of death **Feb 23** 19 **46** at **7:15 A M**

21. I certify that death occurred on the date above stated; that I attended deceased from **Feb 20** 19 **46**, to **Feb 23** 19 **46**, and that I last saw him alive on **Feb 23** 19 **46**.

Immediate cause of death **Cerebral aneurysm with Hypertension**
 Due to **arteriosclerotic disease with Hypertension**
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature **W. M. Brumley**
 M. D. or other _____
 Address **Baltimore** Date signed **2-23-46**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 1 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-7

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BaltimoreCity or town Turner's St., Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto-City or town Turner's St.
(If outside city or town limits, write RURAL and give nearest town)Street No. 118 Dellers St. Road Dundalk
(If rural, give LOCATION) 22 rd

2.(a) If veteran, name war

3. (a) FULL NAME

James Grey

3. (b) Social Security Number

4. Sex M 5. Color or race col 8.(a) Single, married, widowed, or divorced widower6.(b) Name of husband or wife unknown7. Birth date of deceased (mo., day, yr.) unknown 8.(c) If alive, give age _____ years8. AGE: Years 90 years Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation valer11. Industry or business valer12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Rebecca ScottAddress 118 Dellers St. Rd.17. Burial Date thereof Feb 16, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount Zion CemeteryLocation Lanham Baltimore Md18. Funeral director George A. GaltmanAddress 1135 Leonard Hillam19. 2-15 19 46 George A. Galtman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13th 1946 at 8:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2nd 1946 to February 13th 1946; and that I last saw him alive on February 12th 1946Immediate cause of death arterio sclerosis andmitral insufficiency

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J.H. Thomas M.D.Address Turner's St., Md. M. D. or other 2/13/46

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1339

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3228 Magnolia Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No. 212-07-7581

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife Betty A. Craig

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1876

8. AGE: Years

69

Months

11

Days

9

If less than one day

hr.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Retired Printer

11. Industry or business

12. Name John Gardner

13. Birthplace Md.

14. Maiden Name Angeline Colburn

15. Birthplace Md.

16 (a) Informant Mrs Betty A. Gardner

(b) Address 3228 Magnolia Rd

17 (a) Burial

(b) Date thereof 2/4/46

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Blvd

18 (a) Funeral director John F. Hennings

(b) Address 7145 Light St.

19 (a) 2/5/46 (b) A.W. Hedrick

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3228 Magnolia Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1946, 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16, 1946 to Feb 1, 1946, and that I last saw him alive on Jan 31, 1946.

Immediate cause of death

Myocardial Insufficiency

Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John G. Hedrick

PHYSICIAN

Underline the cause to which death should be charged statistically.

EASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 59 yrs 9 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 59 yrs 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Horace L. Gainer

3. (b) Social Security Number

None

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

s

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

11 - 11 - 1870

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

7531

_____ hrs. _____ min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Edwin Gainer

13. Birthplace

Va

14. Maiden name

Emma E. Hederick

15. Birthplace

MD

16. Informant

Hospital records

Address

17.

Burial

Date thereof

2-16-46
(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore, Maryland

18. Funeral director

George J. Schmal

Address

2501 Frederick Avenue Balto. MD

19.

2-15
(Date rec'd by registrar)19. 46Harry D. Miller
Deputy Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1946, at 8:10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 17th1945, to Feb. 121946and that I last saw him alive on Feb. 12, 1946

Immediate cause of death

Pulmonary edema

DURATION

6 hrsDue to acute myocardial insufficiency12daysDue to chronic cardiac vasculature diseaseunknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op. _____

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

M. D. or other

Address Spring Grove St. Hosp. Date signed 2.12.46

RECEIVED

FEB 18 1946

BUREAU V. K.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of name of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

01340

FILM No. I O O FEB 18 1946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ralph

F. Gaw.

3. (b) Social Security Number

215-16-6751

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

--

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

Dec. 22, 1921

8. AGE:

Years

Months

Days

If less than one day

24

1

16

.....hrs.min.

9. Birthplace

Scranton, Pa.

(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER

12. Name

Clarence E. Gaw

13. Birthplace

Phila., Pa.

MOTHER

14. Maiden name

Rae Varian

15. Birthplace

Phila., Pa.

16. Informant

Mrs. Rae V. Gaw

Address

3632 Yolando Rd.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/11/46

(month) (day) (year)

Cemetery or crematory

Baltimore National Cem.

Location

Balto., Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19. (Date rec'd by registrar)

2/9

19. 46

A. W. Hedrick

as Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3632 Yolando Rd.

(If rural, give LOCATION)

World War #2

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 8

19. 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 1-10-46

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed 2/8/46

2/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown on
MARYLAND STATE DEPARTMENT OF HEALTH
 2411 N. Charles St., Baltimore (97)
CERTIFICATE OF DEATH

01341

Reg. Dist. No. 37

FILM No. I O O MAR 6 1946

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 yrs
 Hospital, institution, or street address where death occurred:
Masonic Home
 How long in hospital or institution? 11 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Frederick Md. County Md.
 City or town Mt Airy Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Margaret T. Glisan

3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Rodney T. Glisan
 7. Birth date of deceased (mo., day, yr.) Sept. 18 - 1846 - 1861
 6. (c) If alive, give age _____ years
 8. AGE: Years 84 Months 5 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Lingamore, Frederick Co.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Josiah Peter Smith
 13. Birthplace New London, Md.
 14. Maiden name Sarah Elizabeth Pankler
 15. Birthplace Mt. Airy, Md.

16. Informant Laura M. Schrieder
 Address Masonic Home, Cockeysville Md.

17. Burial Date thereof _____ (month) (day) (year)
 (Burial, cremation, or removal. Which?)

Cemetery or crematory Central M.C.
 Location Frederick Co.

18. Funeral director Geo. F. Buyer, Jr.
 Address 1512 Hollins St.

19. 2/28 19 46 P.M. Schrieder
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 19 46 at 10³⁰ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 18 - 1943 to Feb 26 19 46
 and that I last saw him alive on Feb 26 19 46

Immediate cause of death Cardiac Failure
 DURATION 3 days

Due to Generalized Arteriosclerosis 10 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Salomon Sherman M.D.
 Address 2424 Custer Place Date signed 2/26/46
 M. D. or other

RECEIVED

MAR 1 1946

BUREAU V. M.

CERTIFICATE OF DEATH

Registered No. 38

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 6 Linganore Avenue
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Parkville
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 6 Linganore Avenue
(If rural give location)
- (e) If foreign born, how long in U. S. A. _____ years

3 (a) FULL NAME

Maggie Gaffron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

M.6 (b) Name of husband or wife Nancy L.

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 14 - 18738. AGE: Years 72 Months 2 Days 28 If less than one day _____ hr. _____ min.9. Birthplace Baltimore Md.
(Town, county and state)10. Usual Occupation at home

11. Industry or business

12. Name Engler

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Mrs. Sidney Gaffron(b) Address 6 Linganore Avenue17 (a) Burial (b) Date thereof 2-14-46
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Parkwood
Location Baltimore18 (a) Funeral director Leonard Ruck(b) Address 5312 Harford Road19 (a) 2/14/46 (b) Engler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 - 1946 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 - 1946 to Feb 11 - 1946 and that I last saw him alive on Feb 11 1946.

Immediate cause of death

Coronary of the Colon
obstruction

Duration

12 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
- (e) Means of injury Fallen

23. Signature

Address 6212 Harford Rd Date signed 2/14/46 M. D.

6217

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 01343 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 6 months
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 4 years, 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____
City or town Washington, District of Columbia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 60 New York Avenue, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Anna Marie Goodkey

3.(b) Social Security Number

4. Sex _____ 5. Color or race _____ 6.(a) Single, married, widowed, or divorced _____

female

white

widowed

6.(b) Name of husband or wife Joseph E. Goodkey

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 15, 1867

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name Paul Lang

13. Birthplace Westphalia

14. Maiden name Mary ?

15. Birthplace Germany

16. Informant Hospital records

Address Catonsville-28, Md.

17. Burial Date thereof 2-28-46
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. Elizabeth's

Location Wash. D.C.

18. Funeral director R.R. Schuchman

Address Elliot City, Md.

19. 2-26 19 46 Isadore Tuerk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 19 46 at 10:00 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 19 41 to February 22 19 46

and that I last saw him or alive on February 22 19 46

Immediate cause of death _____ DURATION _____

Broncho pneumonia, right lower lobe

5 das.

Due to Arteriosclerotic cardiovascular disease Indef.

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____

Address Catonsville-28, Md. Date signed 2/22/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 28 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19106

CERTIFICATE OF DEATH

Reg. Dist. No. 0134430

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Wade Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war No.

3. (a) FULL NAME

Sarah Graber

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Charles J. Graber
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Jan, 7, 1879
8. AGE: Years 67 Months 1 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
12. Name Benjamin Gawthrop
13. Birthplace Baltimore Md.
14. Maiden name Unknown
15. Birthplace

16. Informant Mrs. Margaret Graber
Address 9 Wade Ave. Catonsville Md.
17. Burial Date thereof 2/21/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore
18. Funeral director George W. Little
Address 2700 Edmondson Ave.
19. 2/20 19 46 Quintanilha
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-46 19 46, at 5:00AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-10-38 19 38, to 2-19-46 19 46
and that I last saw her alive on 2-19-46 19 46
Immediate cause of death Cerebral Hemorrhage DURATION 3 hrs.
Due to Essential Hypertension 8 yrs.
Due to Cardio-Vascular Renal Disease 5 yrs.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE George Little M. D. or other _____
Address Catonsville 28 Md Date signed 2-19-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:

County Baltimore
 City or town Parkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2606 Maryland Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War II ✓

3. (a) FULL NAME

Moffatt Avery Green

3. (b) Social Security Number

4. Sex m. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mabel (nee Rouse)
 7. Birth date of deceased (mo., day, yr.) July 29, 1922
 6. (c) If alive, give age ? years
 8. AGE: Years 23 Months 6 Days 18 It less than one day hrs. min.

9. Birthplace North Carolina
 (Town, county, and state)
 10. Usual occupation Railroad Workman
 11. Industry or business Penn. R. R.
 12. Name J. D. Green
 13. Birthplace North Carolina
 14. Maiden name Effie Parsons
 15. Birthplace North Carolina

16. Informant E. J. Reynolds
 Address Gray, North Carolina
 17. Burial Date there Feb. 20, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Gray
 Location Gray, North Carolina
 18. Funeral director London M. Brooks
 Address Sparks, Maryland

19. Feb. 19, 19 46 Mrs. Edwards Marblin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1946 at 12:35 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Fractured skull
and multiple fracture
of body

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide A.P. accident Date of Feb. 16, 1946Where did injury occur? Parkton Balto md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) RailroadMeans of injury Injured at work? Yes23. SIGNATURE A. W. France Dep. Med. Exam

M. D. or other

Address Parkton, md Date signed Feb. 16, 1946

RECEIVED
FEB 21 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 013494

1. PLACE OF DEATH:

County BaltoCity or town Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. Marshy Point Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

EUGENE BRIDGEMAN

3.(b) Social Security Number

4. Sex M 5. Color or race Blond 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Ella Griffin7. Birth date of deceased (mo., day, yr.) Jan. 15 - 1879
8.(c) If alive, give age _____ years8. AGE: Years 67 Months 0 Days 24 If less than one day _____ hrs. _____ min.9. Birthplace Balto. Co.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Mr. Henry Griffin13. Birthplace Md.14. Maiden name Unknown

15. Birthplace

16. Informant Susie GriffinAddress Chase, Ind.17. Burial Date thereof 3-12-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sharp St.Location Chase, Md.18. Funeral director Mr. P. A. Elliott & SonAddress 1129 N. Caroline St.19. Feb. 11 19 46 John G. Gmelch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 - 19 46 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION

Due to Stroke due to2nd degree burnsover entire body

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 3/9/46Accident, suicide, or homicide Speeding Date of _____Where did injury occur? Chase, Md. (City or town) _____ (County) _____ (State) _____Injured at home, farm, industry, public place (where?) HomeMeans of injury Superficial Injured at work? no23. SIGNATURE M. B. Davis M. D. or other _____Address Dundalk, Md. Date signed 3/9/46

RECEIVED
MAR 12 1946
BUREAU V.S.

APPEAL LEADER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

0134738
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
9008 Hayford Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9008 Hayford Road
(If rural, give LOCATION)
2.(a) If veteran, name war NO

3. (a) FULL NAME

George H. G. Groshons

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Amalia Groshons

7. Birth date of deceased (mo., day, yr.) Nov 29, 1867 6.(c) If alive, give age NO years

8. AGE: Years 78 Months 2 Days 29 If less than one day hrs. mlp.

9. Birthplace Baltimore MD
(Town, county, and state)

10. Usual occupation Morgan's store clerk

11. Industry or business Local & Groshons

12. Name Local & Groshons

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace Germany

16. Informant Albert G. Groshons

Address 9010 Hayford Rd

17. (Burial, cremation, or removal. Which?) Burial Date thereof 3/2/46

(month) (day) (year)

Cemetery or crematory Parkville

Location Parkville MD

18. Funeral director William G. G. G.

Address 1214 St Paul St

2/28 19 46 A. W. H. H.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 19 46 at 6:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19, 1945 to Feb 28, 1946

and that I last saw him alive on 2-26 19 46

Immediate cause of death Cerebral hemorrhage

DURATION 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. Peake M. D. or other

Address 4508 Hayford Road Date signed 2-28-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 years, 2 months, 10 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 12 years, 2 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 118 South Rochester Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Frieda Gross

3.(b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... William Gross 6.(c) If alive, give age..... ? years
 7. Birth date of deceased (mo., day, yr.)..... 1885?
 8. AGE: Years..... 61 Months..... ? Days..... ? If less than one day..... hrs. min.
 9. Birthplace..... ?
 (Town, county, and state)
 10. Usual occupation..... ?
 11. Industry or business..... ?
 FATHER
 12. Name..... ?
 13. Birthplace..... ?
 MOTHER
 14. Maiden name..... ?
 15. Birthplace..... ?

16. Informant..... Hospital records
 Address..... Catonsville-28, Md.
Buried Date thereof..... 3-14-46
 17. (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Spring Grove State Hospital
 Location..... Catonsville 28, Maryland
 18. Funeral director..... Spring Grove State Hospital
 Address..... Catonsville 28, Maryland
 19. 3-14 1946 Harold H. Miller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 14 1946, at 11:10a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 4 1933 to February 14 1946
 and that I last saw h. or alive on February 14 1946
 Immediate cause of death.....
Pulmonary tuberculosis DURATION..... Indef.
 Due to..... Left upper tuberculous
pneumonia " "
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.
 Autopsy results..... as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... Isadora Tuerk, M.D. M. D. or other
 Address..... Catonsville-28, Md. Date signed..... 2/14-46

RECEIVED

MAR 18 1946

BUREAU OF

ARTESIAN LEADER

PASADENA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01349 43

1. PLACE OF DEATH:

County Baltimore
 City or town Owens - Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balt
 City or town Owens - Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6801 Linden Ave
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Paul Jacob Grove

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Fannie C Grove (Doe)

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 6 1879

8. AGE: Years 66 Months 3 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business Employers various12. Name Truman C Grove13. Birthplace Penna14. Maiden name Fannie M Griffith15. Birthplace Penna16. Informant Mrs Paul J GroveAddress 6801 Linden Ave

17. Burial Date thereof 2/25/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Landon ParkLocation Fredk Road18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Road19. Feb 22 19 46 Mrs. A. L. Reppner

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 19 46 at 6:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw h. _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Coronary Occlusion -

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. O. Wayro M LPhys. M. L. Wayro M L M/D, or other _____Address 6801 Linden Ave Date signed 2/21/46

RECEIVED

FEB 25 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01350

Reg. Dist. No.

1. PLACE OF DEATH:

Fullerton Md. Balto Co.

County.....

City or town..... Fullerton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Balto.

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1911 Etting Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Charles W

Harmon

3. (b) Social Security Number

212-05-3317

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Helena Harmon

7. Birth date of deceased (mo., day, yr.)

Sept 8th 1883

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

62

hrs.

min.

9. Birthplace

Balto Maryland

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

none

FATHER

12. Name

Unknown

13. Birthplace

Balto, Md

MOTHER

14. Maiden name

Lama Cook

15. Birthplace

Balto, Md

16. Informant

Helena Harmon

Address

1911 Etting St, Balto, Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

2-14-46
(month) (day) (year)

Cemetery or crematory

Mt. Auburn Cemetery

Location

Balto, Md.

18. Funeral director

Archibald B. Laddis

Address

2101 McCulloh Street Balto, Md.

19.

(Date rec'd by registrar)

19

46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 11, 1946, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None, to 19

and that I last saw him alive on 19

Immediate cause of death

Heart disease,

coronary occlusion

DURATION

2 11/46

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rollin C. Hudson M.D. P.M.E.

M. D. or other

Address

Judson 4, Md

Date signed 2/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01351
56

1. PLACE OF DEATH: Baltimore
County.....
City or town.....Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....30 years
Hospital, institution, or street address where death occurred:
2 W. Penna. Ave.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....Maryland County.....Baltimore
City or town.....Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.....2 W. Penna. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Harry Arthur Harris

3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6. (a) Single, married, widowed, or divorced.....Married
6. (b) Name of husband or wife.....Grace Knight Harris
6. (c) If alive, give age.....58 years
7. Birth date of deceased (mo., day, yr.).....July 8, 1892
8. AGE: Years.....53 Months.....6 Days.....28 If less than one day..... hrs. min.

9. Birthplace.....Maryland Line, Maryland
(Town, county, and state)
10. Usual occupation.....Electrical Contractor
11. Industry or business.....Self - Proprietor
12. Name.....William T. Harris
13. Birthplace.....Maryland
14. Maiden name.....Emma J. Smith
15. Birthplace.....Maryland

16. Informant.....Mrs. Grace W. Harris
Address.....2 W. Penna. Ave., Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof.....Feb. 8, 1946
(month) (day) (year)
Cemetery or crematory.....Prospect Hill Cemetery
Location.....Towson, Md.

18. Funeral director.....John Burns' Sons
Address.....Towson, Md.
19. Feb 8 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 6 19 46 at 2:41 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45 to Feb 5 19 46
and that I last saw him alive on Feb 5 19 46

Immediate cause of death.....Carcinoma (breast) DURATION.....1 yr.
Due to.....Pregnancy in last 3 mos.
Due to.....Duration 1 one year
Other conditions.....

(Include pregnancy within 3 months of death)
Major findings of operations.....Carcinoma breast
a breast Date of op.....Feb 7 46
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of Injury..... Injured at work?.....

23. SIGNATURE.....John S. Greenup M.D.
Address.....Towson - Md M. D. or other.....
Date signed.....2/7/46

RECEIVED
MAR 1 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

CERTIFICATE OF DEATH

Reg. Dist. No.

01352

1. PLACE OF DEATH:

County Baltimore
 City or town Rogers Forge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

None

3. (a) FULL NAME

Charles William Heisterman IV
Charles William Heisterman

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 21 1936
 8. AGE: 9 Years 6 Months 19 Days If less than one day

8. (c) If alive, give age years
 9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation (School)
 11. Industry or business

12. Name Charles W. Heisterman III
 13. Birthplace Baltimore, Md.

14. Maiden name Gertrude M. Westerfeld
 15. Birthplace Baltimore, Md.

16. Informant Charles W. Heisterman III
 Address 2519 1/2 Creighton Avenue, Harford

17. Burial Burial Date thereof 2/12/46
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. Louis
 Location Frederick, Md.

18. Funeral director George J. Ruth, Inc.
 Address 1735 Harford Avenue

19. 7/11 19 46
 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Parkville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2519 Creighton Ave.
 (If rural, give LOCATION)

None

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1946, at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated that I attended deceased from

19..... to..... 19.....

and that I last saw h..... at..... 19.....

Immediate cause of death

Burned to death (in burning building)
3rd degree burns head & neck

DURATION

2/9/46

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident suicide, or homicide Date of 2/9/46

Where did injury occur? Towson Baltimore
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Business place of father

Means of injury Burning building Injured at work? no

23. SIGNATURE

Rollin C. Hudson MD DME
 M. D. or other
 Address Towson 4 Md Date signed 2/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 01353 44

1. PLACE OF DEATH:

County BaltimoreCity or town Spaulding (Pt 119) Jonesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Beatrice Hensley4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Clarence Hensley7. Birth date of deceased (mo., day, yr.) July 19158. AGE: Years 30 Months 0 Days 0 If less than one day 0 hrs. 0 min.9. Birthplace Pa.
(Town, county, and state)10. Usual occupation —11. Industry or business —12. Name Thomas B. Musselman13. Birthplace Va.14. Maiden name Olie Jane Gordon15. Birthplace Va.16. Informant Carlos & Cecil MusselmanAddress —17. Removal Date thereof 2/27/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory —Location Brounake Va.18. Funeral director John J. DonnellyAddress 718 Eastern Ave. Essex 2119. 2/27/46 Donnelly
(Date rec'd by registrar) (month) (day) (year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State — County —City or town —
(If outside city or town limits, write RURAL and give nearest town)Street No. —

(If rural, give LOCATION)

2. (a) If veteran, name war —

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1946 at 7:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw him alive on 19Immediate cause of death Shock

DURATION

Due to 2nd degree burn overentire bodyDue to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —— Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 2-25-46Accident, suicide, or homicide Accident Date of 2-25-46Where did injury occur? Sp. Pt. 19 Bacon md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Burned - apt. 1202 Injured at work? No23. SIGNATURE M.D. Davis M.D.Address Wm. H. Davis - Baltimore M.D. or other M.D.Date signed 2/28/46

RECEIVED
MAR 22 1946
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 01354

1. PLACE OF DEATH:

County BaltimoreCity or town Sp Pt (19) Jones Creek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto.City or town Jones Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

James Hensley

3. (b) Social Security Number

4. Sex m5. Color or race W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) 19328. AGE: Years 14 Months - Days - It less than one dayhrs. - min.9. Birthplace Va.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Pharence L Hensley13. Birthplace Va.14. Maiden name Beatrice Elva Musselman15. Birthplace Va.16. Informant Carol MusselmanAddress Va.17. Removal Removal

(Burial, cremation, or removal. Which?)

Date thereof 2/27/46

(month) (day) (year)

Cemetery or crematory

Location Roanoke Va.18. Funeral director John J ConnollyAddress 408 Eastern Ave. Essex 2119. 2/26 19 46

(Date rec'd by registrar)

John J Connolly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 19 46 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 - to 19 -and that I last saw h. - alive on 19 -Immediate cause of death Stroke

DURATION

Due to 3rd degree burnsfrom entire body

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-25-46Where did injury occur? Sp Pt 19 - Sar to Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury Burned in apr body Injured at work? No.23. SIGNATURE MB Davis MDDate signed 2/26/46Address Sp Pt 19 - Sar to MdDate signed 2/26/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 282

CERTIFICATE OF DEATH

01355

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore County
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 1 mo.

Hospital, institution, or street address where death occurred:

Hood Courtasant HomeHow long in hospital or institution? 3 yrs 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)Street No. 1941 N. Lombard Street
 (If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Amelia Hessonour (Hessenauer)

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced -6. (b) Name of husband or wife Christian Hessonour6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) September 24, 18638. AGE: Years 82 Months 4 Days 18 If less than one day - hrs. - min.9. Birthplace Baltimore, Maryland
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business -12. Name Charles Ross13. Birthplace Germany14. Maiden name Amelia Nerse15. Birthplace Germany16. Informant Mrs. MarshallAddress 9308 Sargy on Detroit Mich.17. (Burial, cremation, or removal. Which?) Burial Date thereof Feb 15, 1946
 (month) (day) (year)Cemetery or crematory Lincoln ParkLocation Baltimore Maryland18. Funeral director Logan L. SchwabAddress 2101 Frederick Avenue19. R-15 46 Charles H. Miller
 (Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 19 46 at 12:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 19 46 to Feb 12 19 46and that I last saw him/her alive on Feb 11 19 46Immediate cause of death Chr. MyocarditisDue to Arterio Sclerotic Cardiovascular DiseaseDue to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Jesse Estwood M, D. or other -Address Catonsville Date signed 2-12

RECEIVED
FEB 18 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

CERTIFICATE OF DEATH

Reg. Dist. No. 01356 42

1. PLACE OF DEATH

County BaltimoreCity or town Halethorpe
(if outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

4612 Linden ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Halethorpe
(if outside city or town limits, write RURAL and give nearest town)Street No. 4612 Linden ave
(if rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Sadie Elizabeth Hilleary

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married9. (b) Name of husband or wife Albert W. Hilleary7. Birth date of deceased (mo., day, yr.) Feb 5/18839. (c) If alive, give age 64 years8. AGE: Years 64 Months 0 Days 9
If less than one day
.....hrs.min.9. Birthplace Baltimore city, Md
(Town, county, and state)10. Usual occupation housewife11. Industry or business housework12. Name Robert Walter Watkins13. Birthplace Petersburg Va.14. Maiden name Sadie M. Kugel15. Birthplace Baltimore Md16. Informant Mr. Albert W. HillearyAddress 4612 Linden ave, Halethorpe17. Burial Date thereof 2/18/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Louisa Park Cem.Location Balto., Md.19. Funeral director WM. J. TICKNER & SONSAddress Baltimore, Md.19. 2/15 19 46 J. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 19 46 at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 44 to Feb 14 19 46and that I last saw her alive on Feb 14 19 46Immediate cause of death apoplexyDue to chr. myocarditisDue to arterial hypertensionOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Hedrick M.D. or otherAddress 5609 Main St Halethorpe Date signed 2/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of maiden name of mother of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01357

Reg. Dist. No. 44

FILM No. I O 1 MAR 26 1946

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 98 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, Maryland

How long in hospital or institution? 98 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town 1904 N. Wolfe St., Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. See above

(If rural, give LOCATION)

2. (a) If veteran, name war

WW-2

3. (a) FULL NAME

FRANK HOBNER

3. (b) Social Security Number

212-26-7013

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

5-21-06

8. AGE:

Years

Months

Days

If less than one day

39

8

10

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Produce Business

11. Industry or business

FATHER
MOTHER

12. Name

Nicholas F. Hobner

13. Birthplace

Baltimore, Md.

14. Maiden name

Ida Baker BEHR Baker

15. Birthplace

Baltimore, Maryland

16. Informant

Clinical Records, Vets. Adm. Hosp.

Address

Fort Howard, Maryland

17.

Burial

Date thereof

2-4-46

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mount and Memorial

Location

Baltimore

18. Funeral director

Leonard J. Ruck

Address

5305 Harford Rd., Balto., Md.

19.

2/2 46

19.

Amg

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1946 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 26, 1945 to February 1, 1946

and that I last saw him alive on February 1, 1946

Immediate cause of death Disease of the Heart

Coronary arteriosclerosis,

Coronary Occlusion, cardiac enlarge-

ment, Myocardial Insufficiency

Anginal syndrome

DURATION

3 Mos.

plus

Due to

Other conditions Obesity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Amg Balter

A. M. BALTER, LT. COL., M.C. or CLIN. DIR.

Fort Howard, Maryland Date signed 2-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CHANGE OF AGE Letter.
from Dr. Weltmer, Spring Grove, Filmed 3-7-46 G100-L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01358

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Baltimore
City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 4 years, 9 months
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution?..... 4 years, 9 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
City or town..... Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 3005 Arizona Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Augustine C. Hoeflich

3.(b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed
6.(b) Name of husband or wife..... ? 6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... October 24, 1859 1860
8. AGE: Years..... 85 86 Months..... 4 Days..... 3 If less than one day..... hrs. min.
9. Birthplace..... Balto. Md.
(Town, county, and state)
10. Usual occupation..... Housewife
11. Industry or business..... Home
FATHER 12. Name..... Frederick Quatmann
13. Birthplace..... Germany
MOTHER 14. Maiden name..... Fink
15. Birthplace..... ?

16. Informant..... Hospital records
Address..... Catonsville-28, Md.
17. Burial (Burial, cremation, or removal, which?) Date thereof..... 3/2/46
(month) (day) (year)
Cemetery or crematorium..... Balto.
Location..... Balto. Md.
18. Funeral director..... William Cook Inc.
Address..... 1217 St. Paul St
2/28 46
19. (Date rec'd by registrar) 19. 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 27..... 1946 at 6:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 27..... 1941 to February 27..... 1946

and that I last saw him or her alive on February 27..... 1946

Immediate cause of death.....	DURATION
<u>Chronic myocarditis</u>	<u>Indef.</u>
Due to..... <u>Generalized arteriosclerosis</u>	<u>"</u>
Due to..... <u>Bilateral ovarian cysts</u>	<u>"</u>
Other conditions.....	
(Include pregnancy within 3 months of death)	

Major findings of operations.....

..... Date of op.

Autopsy results..... As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Signature..... Isadore Tuerk, M.D.
M. D. or other

Address..... Catonsville-28, Md. Date signed..... 2/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01359

Reg. Dist. No.

44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 Hrs. 55 Minutes

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 10 Hrs. 55 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 119 Scott St.
(If rural, give LOCATION)2. (a) If veteran, name war WW-I

3. (a) FULL NAME

WILLIE T. HOLLOMAN

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Teresa Holloman6. (c) If alive, give age 31 years7. Birth date of deceased (mo., day, yr.) 7-4-96

8. AGE: Years Months Days If less than one day

49724

.....hrs.min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Chauffeur

11. Industry or business

12. Name Bird Holloman13. Birthplace Virginia14. Maiden name Lillie Bailey15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Md.17. Burial Date thereof March 2/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.18. Funeral director A. Lee OderAddress 4644 York Road., Balto., Md.19. 3/1 19. 46 A. W. Hedrick
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1946 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 27, 1946 to February 28, 1946and that I last saw him alive on February 28, 1946

Immediate cause of death

Primary Carcinoma of liver

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Primary Carcinoma of liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. BALTERA.M. BALTER, LT. COL., M.C. CLIN. DIR.Address Ft. Howard, Md. Date signed 2-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01360

Reg. Dist. No. *KK*

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 363 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 363 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2121 Dukeland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3.(a) FULL NAME

WALTER F. HOOD

3.(b) Social Security Number

212-05-7043

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	---

8.(b) Name of husband or wife Eva B. Hood6.(c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) 7-17-97

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>6</u>	<u>17</u>hrs.min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Stockman G&E Co.

11. Industry or business

12. Name Francis Hood13. Birthplace Baltimore, Maryland14. Maiden name Alice Harrington15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland17. Burial Date thereof 2/7/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Wm. J. Tickner & SonsAddress North & Penn. Aves, Balto., 17

Md.

19. 2/5 46 Wm. J. Tickner & Sons
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 46 at 8:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6, 45 to February 4, 46and that I last saw him alive on February 4, 46Immediate cause of death Carcinoma of Thyroid Gland

DURATION

2-1/2 Yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. BalterAddress Fort Howard, Maryland Date signed 2-4-46

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01361

P

1. PLACE OF DEATH

County Baltimore

Village or City

Registration Dist. No.

No. Bellona & Brightside Aves. St.,

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME Isabel Luke Hopkins

If U. S. Veteran, specify WAR

(a) Residence: No. Bellona & Brightside Aves.St. Bellona & Brightside Aves. Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)widowed

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE ofRobert Dixon Hopkins6. DATE OF BIRTH (month, day, and year) August 3, 1863

7. AGE

Years

82

Months

6

Days

17If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.housewife9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Data deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

(State or country)

MOTHER FATHER

13. NAME

William Luke

14. BIRTHPLACE (city or town)

(State or country)

Scotland

15. MAIDEN NAME

Rose Lindsay

16. BIRTHPLACE (city or town)

(State or country)

Scotland

17. INFORMANT

Mr. D. Luke Hopkins

(Address)

Bellona & Brightside Aves.

18. BURIAL, CREMATION, OR REMOVAL

Place Loudon Park Cem'ty. Date 2/23/46, 19

19. UNDERTAKER

John O. Mitchell & Sons, Inc.
(Address) 1900 Eutaw Place, Baltimore, Md.

20. FILED

2/23, 19 46. A.W. Hedrich
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July 20, 1946
(Month) (Day) (Year)

22.

I HEREBY CERTIFY, That I attended deceased from

Dec, 1943, to 2/20, 1946I last saw him alive on 2/19, 1946; death is saidto have occurred on the date stated above, at 10:30 pm.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Cerebral hemorrhage Instantly

Other Contributory Causes of Importance:

Cerebral sclerosis
Myocarditis
Hypertension

Name of operation

Date of

What last confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

M. H. Hardy
(Address) 1403 Park Ave., Balto., Md.

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

FEB 23 1946

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH

County Baltimore
 City or town Randallstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Liberty Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Randallstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Liberty Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eugene Thomas Horton

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

8.(b) Name of husband or wife

Eva D Horton

B.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Sept. 12, 1898

8. AGE:

Years

Months

Days

If less than one day

47422

hrs.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual occupation

Used Car Dealer

11. Industry or business

Self

FATHER

12. Name

Eva D Horton

MOTHER

13. Birthplace

Dayford Co Md

14. Maiden name

Estelle Jeff

15. Birthplace

Baltimore Md

16. Informant

Mrs. Eva Horton

Address

Randallstown Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/2/46
(month) (day) (year)

Cemetery or crematory

Woodlawn

Location

Woodlawn Md

18. Funeral director

Sam J. Robinson & Sons

Address

Penn & North Ave

19.

2/4/46
(Date rec'd by registrar)

19.46

Sam J. Robinson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 4, 1946 ⁵⁵ 16-2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 4, 1946 to Feb. 4, 1946and that I last saw him alive on Feb. 4, 1946

Immediate cause of death

Coronary thrombosis

DURATION

1 hr

Due to

myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sam J. Robinson

M. D. or other

Address

Randallstown Date signed 2/4/46

RECEIVED

FEB 12 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH County <u>Baltimore</u> City or town <u>Baltimore - 6</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>20 Kolb Ave</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Ind</u> County <u>Baltimore</u> City or town <u>Baltimore - 18</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>303 E. 25th St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3.(a) FULL NAME <u>ANNA V. Huddle</u>				3.(b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Widowed</u>		MEDICAL CERTIFICATION	
6.(b) Name of husband or wife <u>Albert B Huddle</u>				20. DATE OF DEATH <u>Feb. 6</u> 19 <u>46</u> at <u>1:45 p.m.</u>			
6.(c) If alive, give age years				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from			
7. Birth date of deceased (mo., day, yr.) <u>Aug 6 1866</u>				end that I last saw h..... alive on 19.....			
8. AGE: Years <u>79</u>		Months <u>6</u>		Days <u>0</u>		If less than one day hrs. min.	
9. Birthplace <u>Virginia</u> (town, county, and state)				Immediate cause of death <u>Myocardial Infarction</u>			
10. Usual occupation <u>At Home</u>				Due to <u>Coronary Occlusion</u>			
11. Industry or business				Other conditions			
12. Name <u>George Stanley</u>				(Include pregnancy within 8 months of death)			
13. Birthplace <u>England</u>				Major findings of operations			
14. Maiden name <u>Rebecca O'Roark</u>				Date of op.			
15. Birthplace <u>Virginia</u>				Autopsy results			
16. Informant <u>Mrs Walter H Schmidt</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
Address <u>303 E 25th St</u>				22. VIOLENCE: If death was due to external causes, fill in the following:			
17. Burial Date thereof <u>Feb 10 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year)				Accident, suicide, or homicide Date of			
Cemetery or crematory <u>United Bretheran</u>				Where did injury occur? (City or town) (County) (State)			
Location <u>Shenandoah Page Co. Va.</u>				Injured at home, farm, industry, public place (where?)			
18. Funeral director <u>Lassahn Funeral Home</u>				Means of injury Injured at work?			
Address <u>7401 Belair Road</u>				23. SIGNATURE <u>M. B. Davis M.D.</u>			
19. W.A.S. 19 <u>46</u> <u>Mrs. A. L. Ridenour</u> (Date rec'd by registrar) Registrar				Address <u>Shenandoah - Va</u> Date signed <u>2/6/46</u>			

RECEIVED

FEB 13 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 01364 38

1. PLACE OF DEATH:

County Balto.City or town Loch Raven, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Loch Raven
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war World War II

3. (a) FULL NAME

Thomas Mitchell Jenifer

3. (b) Social Security Number

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

marriedB. (b) Name of husband or wife Margaret M. Jenifer

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 15-19018. AGE: Years 44 Months 7 Days 4 It less than one day _____ hrs. _____ min.9. Birthplace Loch Raven - Md.
(Town, county, and state)10. Usual occupation Lawyer11. Industry or business Law12. Name Thomas R. Jenifer13. Birthplace Balto. Co. - Md.14. Maiden name Edith Mae Mitchell15. Birthplace La Plata, Charles Co., Md.16. Informant Walter M. Jenifer (Bm)Address Towson - Md.17. Burial Date thereof 2-22-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prospect HillLocation Towson, Md.18. Funeral director Stewart & Mowen Co.Address 108 W. North - Baltimore19. Feb 21 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19th 19 46 at _____ M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1945 to Feb 1946 and that I last saw him alive on Feb 18th 19 46

Immediate cause of death _____ DURATION

Acute Cardiac CollapseDue to MyocardiumDue to Alcoholism

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Danice of A. M. Jenifer M. D. or other _____Address Towson, Md Date signed Feb 20, 1946

RECEIVED

MAR 1 1946

BUREAU

STATE OF MARYLAND—CERTIFICATE OF DEATH

01365

1. PLACE OF DEATH

County Baltimore
Village or City CatonsvilleNo. Shady Nook Ave.Registration Dist. No. 30

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 13 yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.2. FULL NAME Mary S. Jenkins

If U. S. Veteran, specify WAR _____

(a) Residence: No. Shadynook Ave.

St. _____ Ward _____

(Usual place of abode)

If nonresident give city or town and State _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day, and year) Nov. 27, 18647. AGE Years 81 Months 2 Days 19 If LESS than 1 day, _____ hrs. or _____ min.8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. _____

10. Date deceased last worked at this occupation (month end year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Washington State
(State or country)13. NAME John F. Jenkins14. BIRTHPLACE (city or town) Mass.
(State or country)15. MAIDEN NAME Elizabeth S. David16. BIRTHPLACE (city or town) Pa.
(State or country)17. INFORMANT Mr. John F. Jenkins
(Address) Gladwyne, Pa.18. BURIAL, CREMATION, OR REMOVAL
Place Piermont, N. Y. Date 2/16/46, 194619. UNDERTAKER John J. Mitchell & Son, Inc.
(Address) 1900 Eutaw Place, Balto.20. FILED 2/16, 1946 Nancy Miller
Deputy Registrar. T.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February 15, 1946
(Month) (Day) (Year)22. I HEREBY CERTIFY That I attended deceased from August 1934 to February 1946I last saw him alive on Feb 17, 1946; death is said to have occurred on the date stated above, at 4 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Carcinoma of bladder

Date of onset _____

Other Contributory Causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? Bio. at J. H. H. Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 1946Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) Wetherbee Fort M. D.(Address) 20 E. Preston St., Balto.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *73d*

CERTIFICATE OF DEATH

Reg. Dist. No. *41*

01366

1. PLACE OF DEATH:

County *Balto*
 City or town *Bundalk - 22*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *14 months*
 Hospital, institution, or street address where death occurred:
8210 Bear Creek Drive
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Ba* County *#1*
 City or town *Ba #1*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *Ba #1*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Annie Johns

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Edward B. Johns

7. Birth date of deceased (mo., day, yr.)

Aug - 21 - 1870

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

75

hrs.

min.

9. Birthplace

Baltimore Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name

Unknown

13. Birthplace

"

MOTHER

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Mrs. A. Cockrill

Address

8210 Bear Creek Drive

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Burial Cedar Hill Cem

Location

Annapolis Blvd

18. Funeral director

Phas. F. Dill

Address

1501 E. Fort Ave

19.

(Date rec'd by registrar)

2/18/46 Sw. Redwood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 16. 1946* at *6 A.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1944 to *Feb. 16. 1946*and that I last saw him *or* alive on *Feb. 15* 19 *46*

Immediate cause of death

Coronary Thrombosis

DURATION

1 day

Due to

Hypertensive C.V.

3 yrs.

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis M. Tollin M.D.

M. D. or other

Address *Spawsons Pt. Md.* Date signed *2/16/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B-d*

CERTIFICATE OF DEATH

Reg. Dist. No. *38*

1. PLACE OF DEATH:

County..... *Baltimore, Md.*
 City or town..... *Towson Maryland*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2.6*

Hospital, institution, or street address where death occurred:

409 Fairmount Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
 (If outside city or town limits, write RURAL and give nearest town)Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

John F. Johnson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Caucasian

6.(a) Single, married, widowed, or divorced

*Widower*6.(b) Name of husband or wife..... *Virginia Johnson*

7. Birth date of deceased (mo., day, yr.)

Oct 11th, 1871

5.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

74

hrs. min.

9. Birthplace..... *Springgreen Md. Balto, Co.*

(Town, county, and state)

10. Usual occupation..... *none*11. Industry or business..... *none*12. Name..... *John F. Litcher*13. Birthplace..... *Springgreen Md. Balto, Co.*14. Maiden name..... *Virginia Johnson*15. Birthplace..... *Springgreen Md. Balto Co.*16. Informant..... *Agnes Johnson*Address..... *2712 Poplar St. Philadelphia Pa.*

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof..... (month) (day) (year)

*2-9-46*Cemetery or crematory..... *Pleasant Rest*Location..... *Towson Md. Balto Co.*18. Funeral director..... *Charles G. Gaddis*Address..... *2101 Mc Bullock St. Balto, Md*

19. (Date rec'd by registrar)

*2/8*19. *46**AW Hedrich*

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... *February 4th* 19. *46* at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him alive on *Jan 27th* 19. *46*

Immediate cause of death.....

Myocardial Infarction

Due to.....

Coronary Artery Disease

Due to.....

Senility

Other conditions.....

Chronic Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *Daniel of C. Ho Jennifer*Address..... *Towson Md*Date signed..... *2/6/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 730

CERTIFICATE OF DEATH

Reg. Dist. No. 01368 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 DaysHospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia CountyCity or town Kilmarnock
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2. (a) If veteran, name war WW-I

3. (a) FULL NAME

OCTAVIOUS JONES

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	------------------------------------	--

6. (b) Name of husband or wife Eliza Jones6. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) 5-8-88

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>9</u>	<u>19</u> hrs. min.

9. Birthplace Lancaster County, Va.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Robert Jones13. Birthplace Virginia14. Maiden name Lucy Brokeman15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.
Address Ft. Howard, Md.17. Burial Date thereof 3-2-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Kilmarnock, Va.18. Funeral director Charles R. LawAddress 802 Madison, Balto., Md.19. 3/1 46 Ant...
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1946, at 7:00A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 25, 1946 to February 27, 1946and that I last saw him alive on February 27, 1946Immediate cause of death Arteriosclerotic heart diseaseDURATION
Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Arteriosclerotic heart disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Ann Balt...Address Ft. Howard, Maryland Date signed 2-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01369

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 213 Church Lane
(If rural, give LOCATION)
2. (a) If veteran, name war —

3. (a) FULL NAME

Alice Rose Kennedy

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) Sept. 18 - 1879 8. (c) If alive, give age 66 yrs. years

8. AGE: Years 66 yrs. Months 4 Days 19 If less than one day hrs. min.

9. Birthplace Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Kennedy
13. Birthplace Ireland

14. Maiden name Eliza Conroy
15. Birthplace Ireland

16. Informant William J. Kennedy
Address 211 Church Lane, Pikesville Md.

17. Burial Date thereof Feb 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Charles
Location Pikesville, Maryland

18. Funeral director Frank H. Newell
Address Pikesville, Maryland

19. Feb 5 - 1946 E E Michael
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1944, to Feb 5 1946, and that I last saw him alive on Feb 4 1946.

Immediate cause of death Coronary Thrombosis DURATION Sudden

Due to Arterio Sclerosis ?

Due to Chronic Bronchitis ?

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE E E Michael M.D.
Address Pikesville 8, Md. Date signed Feb 5, 1946

RECEIVED
FEB 8 1946
BUREAU V. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of color is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

FILM No. I 00 FEB 28 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 01370 38

1. PLACE OF DEATH:

County Parkville

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

25 Linganore Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Parkville

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Linganore Avenue
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Annie Klein

3. (b) Social Security Number

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife George John Klein

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 19 - 1878

8. AGE:

Years

Months

Days

If less than one day

67

9

5

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER
MOTHER

12. Name Fred Woodey

13. Birthplace Md.

14. Maiden name Frieda Waltzer

15. Birthplace Md.

16. Informant Mr. Henry G. Klein

Address 4808 Holder Avenue-14-

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof 2/27/46
(month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore

18. Funeral director

Leonard J. Ruck

Address

5305 Harford Road

19. 2/25
(Date rec'd by registrar)

19. 46

G. W. Boone

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1946 at 4:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14, 1943 to Feb 24, 1946
and that I last saw him alive on Feb. 21, 1943

Immediate cause of death

Chronic myocarditis
Chronic arthritis

DURATION

3 yrs. +
6 yrs. +

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. W. Boone M.D.

M. D. or other

Address 2810 Taylor Ave. Date signed 2/25/46

RECEIVED
FEB 26 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01371

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
 County.....
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 years, 1 month, 21 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 22 years, 1 month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1216 Patapsco St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Martha Kraus

3. (b) Social Security Number

4. Sex..... female
 5. Color or race..... white
 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... unk. Julius Krause
 B.(c) If alive, give age..... no years
 7. Birth date of deceased (mo., day, yr.)..... May 11, 1861
 8. AGE: Years..... 84 Months..... 9 Days..... 10 If less than one day..... hrs. min.
 9. Birthplace..... Germany
 (Town, county, and state)
 10. Usual occupation..... Seamstress
 11. Industry or business..... sewing
 12. Name..... John Scherkowski
 13. Birthplace..... Germany
 14. Maiden name..... Katherine Grim
 15. Birthplace..... Germany
 18. Informant..... Hospital Records
 Address..... Catonsville-28, Md.

17. Burial Date thereof..... Febr. 23-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Holy Cross
 Location..... Pitcher Highway A.G.L.O.
 18. Funeral director..... Elizabeth Harkle Inc.
 Address..... 115 E. West St.

19. Feb 22 46 A. M. Hedrick
 (Date rec'd by registrar) (Signature)
A. E. J. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 21 19..... 46, at..... 8:00 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....
 and that I last saw h..... alive on..... 19.....

Immediate cause of death..... Toxemia
 Due to..... Bacterial Pneumonia
 Due to..... fracture right humerus
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... accident Date of..... Feb 21 46
 Where did injury occur?..... Catonsville (City or town) Baltimore (County) Md. (State)
 Injured at home, farm, industry, public place (where?)..... Spring Grove State Hosp
 Means of injury..... fall out of bed on floor Injured at work?..... no

23. SIGNATURE..... Dr. M. Kieffler M. D. or other.....
 Address..... 1010 Leedman Date signed..... 2-21-46

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 44

CERTIFICATE OF DEATH

01372

1. PLACE OF DEATH:

(a) County Balto.
(b) City or town Chesapeake Park
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
8017 Duval Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 3 do

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Ind. (b) County Balto.
(c) City or town Lodge Forrest
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7709 Duquoin Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A. 36 years

3 (a) FULL NAME

Frederick August Krueger

3 (b) If veteran, name war

3 (c) Social Security

No. 213-07-9058

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

nee Bowie Janet Krueger

6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.)

July 11 - 1883

8. AGE:

Years

Months

Days

If less than one day

62

6

26

hr.

min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

Beth Steel (Dp. P. Md.)

MOTHER FATHER

12. Name

William Krueger

13. Birthplace

Germany

14. Maiden Name

Unknown

15. Birthplace

Germany

16 (a) Informant

Fred. H. Krueger

(b) Address

8017 Duval Ave.

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

2-9-46
(month) (day) (year)

(c) Cemetery or crematory

Parkwood

Location

Taylor Ave.

18 (a) Funeral director

John G. Connolly

(b) Address

418 E. Eastern Ave. Gary

19 (a)

(Date rec'd by registrar)

2-7-46

(b)

John G. Connolly

Registrar

MEDICAL CERTIFICATION

20. Date of death Feb 6 1946, at 11:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to Feb 6 1946, and that I last saw him alive on Feb 6 1946.

Immediate cause of death

Cerebral

Apoplexy

Due to arterio-sclerotic

cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

3 days

Underline the cause to which death should be charged statistically.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Geo. M. Baumgardner

M. D. or other

Address Balto 6 Ind

Date signed 2-6-46

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 11 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

01373

Reg. Dist. No. 42

1. PLACE OF DEATH

County BaltimoreCity or town Landsdowne
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Landsdowne
(If outside city or town limits, write RURAL and give nearest town)Street No. 322 First St
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Fredrick H. Kuechle

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Katherine Mueller

7. Birth date of deceased (mo., day, yr.)

Jan 23rd 1885

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

6315

hrs.

min.

9. Birthplace

Baltimore, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Fredrick Kuechle

13. Birthplace

Germany

MOTHER

14. Maiden name

Germany

15. Birthplace

18. Informant

Katherine S. Kuechle

Address

322 First St Landsdowne

17.

(Burial, cremation, or removal, which?)

Date thereof

Mar 4/46
(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore, Md

18. Funeral director

F. J. Kuechle, Inc.

Address

300 Eutaw Place

19.

March 2 1946A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28th 1946 at 7:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 26 1946 to Feb 28 1946and that I last saw him alive on Feb 27 1946

Immediate cause of death

Coronary Occlusion

DURATION

2 wksDue to Arteriosclerosis Cordis?Due to vascular disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Care Kuechle
1326 H Lombard St

M. D. or other

Date signed 3/1/46

Xth Roeding

1326 Lombard near Tucker

1809 Sesota Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Evidence for change of

age of deceased

is shown on

STATE OF MARYLAND—CERTIFICATE OF DEATH

01374

1. PLACE OF DEATH

FILM No. 101 MAR 13 1946

County Baltimore

Village or City Sparrows Point

No. 703 C St.

Registration Dist. No. 44

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Harry C. Lane

If U. S. Veteran, specify WAR

(a) Residence: No. 703 C. St.

St. Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

married

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Belle Ennis

6. DATE OF BIRTH (month, day, and year) March 22, 1871

7. AGE

Years

Months

Days

If LESS than
1 day, --- hrs.
or --- min.

74

-75-

11

4

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.

Engineer

9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.

Bethlehem Steel Co.

10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town) Baltimore

(State or country)

Maryland

FATHER

13. NAME Henry Clay Lane

14. BIRTHPLACE (city or town) Md.

(State or country)

MOTHER

15. MAIDEN NAME Mary Ellen O'Connor

16. BIRTHPLACE (city or town)

(State or country)

Md.

17. INFORMANT Mrs. Belle E. Lane

(Address) 703 C St., Sparrows Point, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Western Cem'ty Date 3/1/46

19. UNDERTAKER John O. Mitchell & Sons, Inc.

(Address) 1900 Eutaw Place, Balto., Md.

20. FILED

45628, 19. 46

Dorson L. Harber

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February

25

1946

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY, That I attended deceased from

February 23, 1946, to February 25, 1946

I last saw him alive on February 25, 1946; death is said

to have occurred on the date stated above, at 11:50 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Coronary Occlusion

Date of onset

2-25-46

Other Contributory Causes of Importance:

Arteriosclerotic Heart Dis.

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed)

Dorson

M. D.

(Address) 520 D St., Sparrows Pt., Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic servitude for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01375

Reg. Dist. No. 40

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrsHospital, institution, or street address where death occurred: 27 yrsHow long in hospital or institution? 27 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Baltimore County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 27 yrs
(If rural, give LOCATION)2.(a) If veteran, name war 27 yrs

3. (a) FULL NAME

Wouise B Wauer

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

John Wauer

7. Birth date of deceased (mo., day, yr.)

Apr 21, 18656.(c) If alive, give age 27 yrs

8. AGE:

Years

Months

Days

If less than one day

80

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Telephone operator

11. Industry or business

Commercial Trust Co

FATHER

12. Name

?

13. Birthplace

Md.

MOTHER

14. Maiden name

?

15. Birthplace

?

16. Informant

Mrs Marie Burton

Address

Baltimore, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 19, 1946
(month) (day) (year)

Cemetery or crematory

Mary. Cathedral

Location

18. Funeral director

Chas F. Gross

Address

Baltimore, Md.

19.

(Date rec'd by registrar)

Feb. 18

19.

C. E. Arthur

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1946, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 11, 1939, to February 16, 1946and that I last saw him alive on February 14, 1946

Immediate cause of death

Congestive Heart Failurewith decompensationDue to Hypertensive Cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clifford F. Hudson, M.D.

M. D. or other

Address Baltimore, Md. Date signed 2/17/46

RECEIVED
FEB 26 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (36)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3708 Eldorado Avenue
(If rural, give LOCATION)2. (a) If veteran, name war NW-2

3. (a) FULL NAME

JAMES J. LIBERTINI

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife Single

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-208. AGE: Years 25 Months 8 Days 8 If less than one day hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Unemployed - Student11. Industry or business Loyola College12. Name Frank Libertini13. Birthplace Italy14. Maiden name Antionetta Genco15. Birthplace Italy16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland17. Burial Date thereof 2-7-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Vincent'sLocation Baltimore18. Funeral director Leonard J. RuckAddress 5305 Harford Road - Lt.19. 2-4 46 W. H. H. H. H. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 19 46 at 11:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2, 19 46 to February 3, 19 46 and that I last saw him alive on February 3, 19 46Immediate cause of death Acute anterior PoliomyelitisDURATION 7 Days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Balter
A. M. BALTER, LT. COL., M.C. or CLIN. DIR.Address Fort Howard, Md. Date signed 2-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

01397

Reg. Dist. No.

1. PLACE OF DEATH

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Katherine Robt. Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

Ella Liberty

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Unknown

8. AGE:

Years

Months

Days

If less than one day

70Winchester, Va.

(Town, county, and state)

10. Usual occupation

house work

11. Industry or business

at home

12. Name

William Liberty

13. Birthplace

Ireland

14. Maiden name

Mary Quigley

15. Birthplace

Ireland

16. Informant

Mr. Thomas C. Martin

Address

1025 W. Lombard St.17. Burial

Date thereof

2/21/46

(month) (day) (year)

Cemetery or crematory

New Cathedral Ave

Location

4300 Old Frederick Road

18. Funeral director

John Towan

Address

901-03 Collins St.19. 2-1919 46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MD County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1025 W. Lombard St.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17, 1946 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1st 1944 to Feb. 17, 1946and that I last saw him er alive on February 17, 1946Immediate cause of death Hypertension andArteriosclerosis.DURATION 2 yearsDue to 10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm. S. Shanahan

1945 W. Baltimore

Date signed 2-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-7)

CERTIFICATE OF DEATH

Reg. Dist. No. 01378 32

1. PLACE OF DEATH:

County BaltimoreCity or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs., 2 mos., 16 daysHospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis SanatoriumHow long in hospital or institution? 5 yrs., 2 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.City or town Alberton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Edward Lightman

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Mrs. Lola Lightman

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 6, 18918. AGE: Years 54 Months 8 Days 14 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Cook

11. Industry or business

12. Name William Lightman13. Birthplace ? - Unknown14. Maiden name Frances Brumley15. Birthplace Baltimore, Maryland16. Informant Edward LightmanAddress Alberton, Balto. Co., Md.17. Burial Date thereof Feb. 23, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory Good Shepherd CemeteryLocation Howard Co., Maryland18. Funeral director F. C. Higinbotham, Jr.Address Main Street, Ellicott City, Md.19. Feb. 20, 1946 Earl T. Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1946 at 1:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14, 1940 to February 20, 1946and that I last saw him alive on February 20, 1946Immediate cause of death Pulmonary Tuberculosis

DURATION

7 Yrs.Due to Tubercle Bacilli

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. _____

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D.
M.D. or other _____Address Mount Wilson, Md. Date signed 2/20/46

RECEIVED

FEB 22 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

01379

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 9 mos., 0 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T.B. Sanatorium
 How long in hospital or institution? 0 yrs., 9 mos., 0 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Sparrows Point
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1003 H. Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Dorothy Lynch

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 25, 1929
 8. AGE: Years 16 Months 3 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Bundalk, Maryland
 (Town, county, and state)
 10. Usual occupation Student
 11. Industry or business
 12. Name Joseph Lynch
 13. Birthplace Baltimore, Maryland
 14. Maiden name Julia Dony
 15. Birthplace Baltimore, Maryland

16. Informant Dorothy Lynch
 Address 1003 H.St., Sparrows Pt., Md.
 17. Burial Feb. 25, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Holy Redeemer Cemetery
 Location 4430 Belair Road, Balto., Md.
Phillip Herwig & Sons
 18. Funeral director
 Address 2024 Orleans St., Balto., Md.

19. Feb. 21, 1946 Earl J. Webster
 (Date rec'd by registrar) (per D. Mayor) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1946 at 4:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 21, 1945 to Feb. 21, 1946
 and that I last saw h. er alive on February 21, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 1 Yr.
 Due to Tubercle Bacilli
 Due to
 Other conditions Diabetes Mellitus 11 Yrs.
Tuberculous Empyema 4 Mos.
 (Include pregnancy within 3 months of death)
 Major findings of operations No operation
 Date of op.
 Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Stewart S. Maffey M.D. M. D. or other
 Address Mount Wilson, Md. Date signed 2/21/46
Rec'd by Dr. E.E. Nichols - 2-23-46

RECEIVED

FEB 25 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ~~correct~~ age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 01380

1. PLACE OF DEATH:

County BaltimoreCity or town Ft. Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 Hrs. 7 Minutes

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Md.How long in hospital or institution? 8 Hrs. 7 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 407 N. Rose St.
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

3.(a) FULL NAME

JOHN G. MARBELL (Mybohn)

3.(b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	---

6.(b) Name of husband or wife Mrs. Rose Marbell6.(c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) 11-7-90

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>2</u>	<u>11</u> hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Copper Welder

11. Industry or business

12. Name William Marbell13. Birthplace Germany14. Maiden name Barbara Lesline15. Birthplace Germany16. Informant Clinical Records, Vets. Adm. Hosp.
Address Ft. Howard, Md.17. Burial
(Burial, cremation, or removal, which) Date thereof Feb. 23/46
(month) (day) (year)
Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.18. Funeral director Chris Miller
Address 2334 Jefferson St., Balto., Md.19. Feb. 21 19 46
(Date rec'd by registrar)Am. Hader
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 19 46, at 8:37 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 18, 19 46, to February 18, 19 46
and that I last saw him alive on Feb. 18, 19 46

Immediate cause of death

Arteriosclerotic heart disease

DURATION

Unknown

Due to

Due to

Other conditions Broncho-pneumoniaUnknown

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Arteriosclerotic heart disease
Broncho-pneumonia
PHYSICIAN: Please underline the cause of death charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Am. Balter
A. M. BALTER, LT. COL., M.C.M. RET'D DIR.
Address Ft. Howard, Md. Date signed 2-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 42

CERTIFICATE OF DEATH

01381

Reg. Dist. No. 44

1. PLACE OF DEATH:

County 2704 North Point Rd.City or town Baltimore 22
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 months

Hospital, institution, or street address where death occurred:

Baltimore County

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

James Franklin Masincepp

3. (b) Social Security Number

224-07-9498

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Nov 15, 1910

8. AGE:

Years 35 Months 3 Days 9 If less than one day
..... hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Barber

11. Industry or business

Haircutting

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Removal

(Date rec'd by registrar)

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946, at 1:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 24 1946, to same 1946.and that I last saw him alive on Feb. 24 1946.

Immediate cause of death..... DURATION

Generalized carcinomatosis 6 wks.

Due to.....

Carcinoma of Lung. 263 mo.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Carcinoma Lung.Date of op. Jan. 19, 1946

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Louis N. Tollin. M.D.Sparrows Point M. D. or otherAddress..... Date signed 2/24/46

RECEIVED
MAR 1 1946
BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 01382429

1. PLACE OF DEATH:

County Baltimore
 City or town Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4707 Kenwood Ave

How long in hospital or institution?

3. (a) FULL NAME

Emelia C Maul

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 7305 Belair Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteWidowed

6. (b) Name of husband or wife

George Maul

7. Birth date of deceased (mo., day, yr.)

April 5 1856

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

891023

hrs.

min.

9. Birthplace Baltimore County Md

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

FATHER

12. Name

August Wirsing

13. Birthplace

Germany

MOTHER

14. Maiden name

Fredericka Fabig

15. Birthplace

Germany16. Informant Miss Ruth Lassahn

Address

7305 Belair Road

17.

(Burial, cremation, or removal. Which?)

Date thereof

3/2/46

(month) (day) (year)

Cemetery or crematory

Immanuel Lutheran Cem.

Location

Grindon Ave

18. Funeral director

Lassahn Funeral Home

Address

7401 Belair Road

19.

(Date rec'd by registrar)

19.

46Ans. G. L. Reifender

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1946 9.00 AM 19 46 at 9.00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 20 19 46 to Feb 26 19 46
 and that I last saw him alive on Feb 26 19 46

Immediate cause of death

Carcinoma ofstomach

DURATION

Due to

Due to

Other conditions

CachexiaArteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thomas Breunan

M. D. or other

Address

5217 Harford Rd

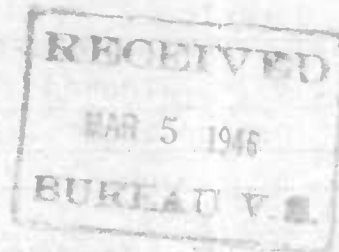
Date signed

3-1-46

Dr. Thos Brumman
5217 Hartford Rd

9-11

7-9



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

CERTIFICATE OF DEATH

01383

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore
 City or town Arbutus
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1235 Linden Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Baltimore
 City or town Arbutus
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1235 Linden Ave
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Matilda M. May

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female W Widow

6. (b) Name of husband or wife late Albert J. May

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1872

8. AGE: Years 73 Months 1 Days 11 If less than one day
 hrs. min.

9. Birthplace Baexo. Ind.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Frederick Wilkens13. Birthplace Germany14. Maiden name Anna -15. Birthplace Germany16. Informant Mrs. Grace S. TermingAddress 1235 Linden Ave.17. Burial Date thereof Feb. 9/46.

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Linden Pk.Location 3801 Frederick Road18. Funeral director Harry A. WitteAddress 401 Edmondson Ave.19. 18 46 Amptst.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7/46. 19. at . M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 10 19. 40 to 2/7 19. 46and that I last saw her alive on 2/6 19. 46

Immediate cause of death

Permeant Anemia

DUE TO

DUE TO

DUE TO

DUE TO

Other conditions Fractured FemurIn ch. art. Due to accidental fall in 1931

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. C. C.Address 2145 N. Baltimore M. D. or otherDate signed 2/8/46

Rev. Chas. A. Cahn 2145 W. Belmont St.

2145-6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yrsHospital, institution, or street address where death occurred: ✓How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 5649 Oregon Ave
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Lynna A. M. Carrow

3. (b) Social Security Number

4. Sex female5. Color or race white6. (a) Single, married, widowed, or divorced married8. (b) Name of husband or wife William J.

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec 31, 18898. AGE: Years 56 Months 1 Days 26 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation house wife11. Industry or business at home12. Name Charles C. Hawley13. Birthplace Howard Co., Md.14. Maiden name Blana Hoffman15. Birthplace Baltimore, Md.16. Informant Mr. William J. M. CarrowAddress 5649 Oregon Ave, Baltimore, Md.17. Burial Date thereof 3/1/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Olivet CemLocation 2930 Frederick Ave18. Funeral director John C. BrownAddress 9016 O. 3rd St.19. Feb 26 19 46 Unkeldm
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1946 at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19 43 to February 26 19 46and that I last saw him alive on February 26 19 46

Immediate cause of death

Cornary Occlusion

DURATION

2 hrsDue to Angina PectorisHypertensive C.V. Disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John F. Coolahan M. D. or other _____Address 4201 Wilkins Ave Date signed 2/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 01385 39

1. PLACE OF DEATH:

County Baltimore
 City or town Phoenix P.O. (Jacksonville)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
Home, Jewettville Pike, Phoenix, Md
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Phoenix P.O. - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Jacksonville
 (If rural, give LOCATION)
 2. (a) If veteran, name war Yes: World War I

3. (a) FULL NAME

Clarence Horatio Medairy

3. (b) Social Security Number

4. Sex Male 5. Color of face White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 12, 1887
 8. (c) If alive, give age — years

8. AGE: Years 58 Months 10 Days 1 If less than one day — hrs. — min.

9. Birthplace Jacksonville Balto Co Md.
 (Town, county, and state)

10. Usual occupation Captain, USMC retired

11. Industry or business

12. Name C. J. Medairy
 13. Birthplace Balto. Co. Md.

14. Maiden name Sarah Ferguson
 15. Birthplace Boyl Co. Md.

16. Informant Clarence Medairy
 Address Phoenix, Md.

17. Burial Date thereof Feb 18, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Natl.
 Location Arlington, Va.

18. Funeral director London M. Brooks
 Address Sparks, Md.

19. 2/17/46 19 46 Anna Price
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13, 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —
 and that I last saw him — days or — weeks or — months or — years

Immediate cause of death Heart disease, chronic myocarditis
Alcoholism, chronic

Due to —
 Due to —

Other conditions Arteriosclerosis
 (Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —

Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

23. SIGNATURE Rollin C. Hudson MD DME
 M. D. or other —
 Address Towson 4, Md Date signed 2/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 28 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltimoreCity or town St. Denis
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 4

Hospital, institution, or street address where death occurred:

1836 Sutton Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town St. Denis
(If outside city or town limits, write RURAL and give nearest town)Street No. 1836 Sutton Ave
(If rural, give LOCATION)2(a) If veteran, name war none

3. (a) FULL NAME

Samuel Mewsshaw

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Mary M. (Blank)Mewsshaw 6. (c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) Sept 21 1897

8. AGE: Years Months Days If less than one day

89 4 14 _____ hrs. _____ min.9. Birthplace Elkridge, Howard Co., Md.
(Town, county, and state)10. Usual occupation Machinist11. Industry or business A. & O. R. Retired12. Name Joseph Mewsshaw13. Birthplace unknown14. Maiden name Sarah Ann Snyder15. Birthplace unknown16. Informant Mrs. Carrie MewsshawAddress 1836 Sutton Ave, St. Denis 3717. Burial Date thereof Feb 7, 1946 (month) (day) (year)Cemetery or crematory McNellie AveLocation Elkridge, Md.18. Funeral director John J. Gorman & SonAddress 900-23 E. Baltimore St.19. 2-6 19 46 (Date rec'd by registrar)W. J. Leggett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 19 46 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1 19 45 to Feb 4 19 46and that I last saw him alive on Feb 4 19 46Immediate cause of death Chronic Bronchitis DURATION2 yearsDecompositionDue to General arteriosclerosisSclerosisDue to Sclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. B. Brumbaugh3609 Main St Elkridge, Md.Address _____ Date signed 2/4/46

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01387

1. PLACE OF DEATH

County Baltimore
 Village or City Middle River

Registration Dist. No. 44

No. 521 Edgewater Apts. Ward 4th
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

2. FULL NAME Carrington Eugene Middleton(a) Residence: No. 521 Edgewater Apts. Ward 4th

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5a. If married, widowed, or divorced
 HUSBAND of (or) WIFE of Eloise Middleton

6. DATE OF BIRTH (month, day, and year) Mar 23/1908

7. AGE Years 37 Months 10 Days 6 If LESS than 1 day, 0 hrs. or 0 min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Guard
 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Martin's Plant.
 10. Date deceased last worked at this occupation (month and year) Feb 1946 11. Total time (years) spent in this occupation 4

12. BIRTHPLACE (city or town) Virginia (State or country) Northumberland Co.13. NAME Arthur Middleton14. BIRTHPLACE (city or town) va. (State or country)15. MAIDEN NAME Clara Clarke16. BIRTHPLACE (city or town) va. (State or country)17. INFORMANT Alma Jane Hughes (Address) Northumberland Co. Va.18. BURIAL, CREMATION, OR REMOVAL Dibson Place Village va. Date 194619. UNDERTAKER William Cook Inc. (Address) 1217 N. Paul St.20. FILED 2-17- 19 46 Phy. G. Connelly

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July 17 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from July 17, 1946 to July 17, 1946

I last saw him alive on July 17, 1946; death is said to have occurred on the date stated above, at 9 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Occlusion Arteriosclerosis
Angina Pectoris 24 hrs

Other Contributory Causes of Importance:

Angina Pectoris 24 hrs

Name of operation Angina Pectoris Date of 24 hrsWhat test confirmed diagnosis? Angina Pectoris Was there an autopsy? 24 hrs

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Angina Pectoris Date of injury 24 hrsWhere did injury occur? Angina Pectoris(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.Manner of injury Angina PectorisNature of injury Angina Pectoris

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Angina Pectoris(Signed) Dr. J. McCarroll M.D. M. D.(Address) Def. Medical Examiner

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95d

CERTIFICATE OF DEATH

01388

Reg. Diat. No. 35-

1. PLACE OF DEATH:

County Baltimore
 City or town Rural near Freeland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 62 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Rural near Freeland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. East of Freeland
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Roy E. Miller

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Estella Morris
 6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) January 6, 1880

8. AGE: Years 66 Months 1 Days 18 If less than one day
 hrs. min.

9. Birthplace Shrewsbury, Pa.
 (Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business Own farm

12. Name Charles Miller

13. Birthplace Penn.

14. Maiden name Margaret Miller

15. Birthplace Penn.

16. Informant Mrs. Miller Strawbridge

Address Freeland, Md. R.D.

17. Burial Date thereof Febr. 27, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion Cemetery

Location Freeland, Md.

18. Funeral director Joseph Hartenstein

Address 17 New Freedom, Pa.

19. Feb 26 19 46 Charles L. Fuller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 19 46 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 46 to Feb. 24 19 46
 and that I last saw him Feb. 24 19 46
 alive on

Immediate cause of death Chronic myocarditis

Due to

Due to

Other conditions Hypertension
Chronic arthritis
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE A. M. Frank M. D. or other

Address Parkton, Md. Date signed Feb. 26, 1946

RECEIVED

MAR 6 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County BaltimoreCity or town Monkton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

HENRY MINESCHIME

3. (b) Social Security Number

NONE4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower8. (b) Name of husband or wife Mary Meyers7. Birth date of deceased (mo., day, yr.) Oct 24 1946 6. (c) If alive, give age _____ years8. AGE: Years 83 Months 3 Days 14 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore Ind
(Town, county, and state)10. Usual occupation Retail Manager11. Industry or business Canning Factory12. Name Michael Minischime13. Birthplace Germany14. Maiden name Dorothy Frances15. Birthplace Germany16. Informant Mrs. Lucille KlingelhorstAddress Monkton Ind17. Burial Baltimore Date thereof Feb 20 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BaltimoreLocation Baltimore Ind18. Funeral director A. Howard EvansAddress 1400 S. Chas. St. Balt. Ind19. Feb 18 19 46 Mrs Howard S. Maddie
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 19 46 at 6:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 19 46 to Feb 12 19 46and that I last saw him alive on Feb 16 19 46Immediate cause of death Cerebral thrombosis

DURATION

Due to _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE P. W. France M. D. or other _____Address Parkton Ind Date signed 2/18/46

CERTIFICATE OF DEATH

RECEIVED
FEB 21 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 304

CERTIFICATE OF DEATH

Reg. Dist. No. 01390 38

1. PLACE OF DEATH:

County..... **Baltimore**
 City or town..... **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **4 years, 4 months, 7 days**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? **4 years, 4 months, 7 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County.....
 City or town..... **4614 Mainfield Avenue**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Baltimore,**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

Francis Michael Moan

3. (b) Social Security Number

4. Sex..... **male** 5. Color or race..... **white** 6. (a) Single, married, widowed, or divorced..... **married**
 6. (b) Name of husband or wife..... **Emma Keenan**
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... **June 12, 1881**
 8. AGE: Years..... **64** Months..... **8** Days..... **15** If less than one day..... hrs. min.

9. Birthplace..... **Baltimore, Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Trucking**
 11. Industry or business..... **Truck**
 FATHER 12. Name..... **James Moan**
 13. Birthplace..... **Ireland**
 MOTHER 14. Maiden name..... **Mary Hughes**
 15. Birthplace..... **Ireland**

16. Informant..... **Hospital records**
 Address..... **Catonsville-28, Maryland**
 17. Burial..... **Burial** Date thereof..... **3/2/46**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Parkwood**
 Location..... **Bald**
 18. Funeral director..... **Leonard J. Ruck**
 Address..... **5305 Harford Road-14-**
 19. **3-2** 19 **46** **Harry S. Miller** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **February 27** 19 **46** at **4:40 a. m.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 20 19 **41** to **February 27** 19 **46**
 and that I last saw him alive on **February 27** 19 **46**

Immediate cause of death.....
General paresis

DURATION
Indef.

Due to.....
 Due to.....
 Other conditions..... **Pylonephritis**
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results..... **as above**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... injured at work?

23. SIGNATURE..... **Isadore Tuerk, M.D.** M. D. or other
 Address..... **Catonsville-28, Md.** Date signed..... **2/27/46**

RECEIVED

MAR 5 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

013918

1. PLACE OF DEATH:

County... Balto.

City or town... Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

809 Regester Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Balto.

City or town... Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 809 Regester Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN T. MORGAN

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Carrie Morgan

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Dec. 6, 1861

8. AGE:

Years

Months

Days

If less than one day

84

1

26

hrs.

min.

9. Birthplace... Calvert Co., Md.

(Town, county, and state)

10. Usual occupation

Car Repair Man (Retired)

11. Industry or business

B. & O. Retired

FATHER

12. Name

Thomas Morgan

13. Birthplace

Calvert Co., Md.

MOTHER

14. Maiden name

Alexina Thomas

15. Birthplace

Calvert Co., Md.

16. Informant

Mrs. Blanche Dorfler

Address

809 Regester Ave.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof...

2/5/46

(month) (day) (year)

Cemetery or crematory

Loudon Park Cem.

Location

Balto., Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

2-4 46
(Date rec'd by registrar)

19.

46

A. Med. J. H.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1946 at 9:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1, 1945 to Feb 2, 1946

and that I last saw him alive on January 25, 1946

Immediate cause of death Coronary Thrombosis

DURATION

24 hrs.

Due to Angina Pectoris

5 yrs.

Due to Essential Hypertension

20 yrs.

& Renal Impairment

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 7301 York Rd Date signed 2-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 820

CERTIFICATE OF DEATH

Reg. Dist. No. 30

01392

1. PLACE OF DEATH:

 County Balto.

 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Nursing Home

 How long in hospital or institution? 6 WRS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Md. County Balto.

 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. Edmondson Ave. & Nunnery Lane
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

CHARLES OLIVER MYERS

3. (b) Social Security Number

none

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widower</u>
-----------------------	----------------------------------	--

 6. (b) Name of husband or wife May Spicer Myers

8. (c) If alive, give age years

 7. Birth date of deceased (mo., day, yr.) Jan. 31, 1865

8. AGE:	Years	Months	Days	If less than one day
<u>81</u>	<u>0</u>	<u>3</u>	<u>hrs.</u>	<u>min.</u>

 9. Birthplace Frederick, Md.
 (Town, county, and state)

 10. Usual occupation Salesman - Retired

11. Industry or business

FATHER	12. Name <u>James Oliver Myers</u>
	13. Birthplace <u>Frederick, Md.</u>

MOTHER	14. Maiden name <u>Mary Reid Yarbrough</u>
	15. Birthplace <u>Frederick, Md.</u>

16. Informant <u>Mrs. John Sanders</u>

17. Burial	Date thereof <u>2/7/46</u> (month) (day) (year)

Cemetery or crematory <u>New Cathedral Cem.</u>

18. Funeral director <u>WM. J. TICKNER & SONS</u>

19. <u>2-6</u>	Date signed <u>4-6</u>

19. <u>4-6</u>	Date signed <u>4-6</u>

19. <u>4-6</u>	Date signed <u>4-6</u>

19. <u>4-6</u>	Date signed <u>4-6</u>

19. <u>4-6</u>	Date signed <u>4-6</u>

19. <u>4-6</u>	Date signed <u>4-6</u>

19. <u>4-6</u>	Date signed <u>4-6</u>

19. <u>4-6</u>	Date signed <u>4-6</u>

MEDICAL CERTIFICATION

 2D. DATE OF DEATH Feb. 4 19 46 at 4 P M

 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 19 40 to Feb 4 19 46 and that I last saw him Feb 4 19 46 alive on

 Immediate cause of death Cerebral Hemorrhage DURATION 3 days

 Due to Cerebral Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

 23. SIGNATURE Wm J Tickner M. D. or other

 Address Baltimore Date signed 2-5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01393

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Batts.
City or town Cockeysville
(If outside city or town limits write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) Lifetime

3. (a) FULL NAME

George Albert Nash

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Sarah B. Kutz Nash

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

Oct 11 1861

8. AGE:

Years 84 Months 4 Days 12 If less than one day hrs. _____ min. _____

9. Birthplace

Sparks, Ind.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farming

12. Name

Joseph Nash

13. Birthplace

England

14. Maiden name

Mattilda Cole

15. Birthplace

Baltimore County

16. Informant

Sarah B. Nash

Address

Cockeysville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb 26/46
(month) (day) (year)

Cemetery or crematory

Grace M. E. Church

Location

Upperco, Md.

18. Funeral director

Edw. E. Giffon

Address

Waverly, Md.

19.

2-23

46

Wilmer C. Ensor

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
City or town Cockeysville Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 46, at 10 A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 19 45, to Feb 23 19 46

and that I last saw him alive on Feb 22 19 46

Immediate cause of death

Chronic Myocarditis

DURATION

2 yrs.

Due to

Arterio sclerosis

Due to

Senility

Other conditions

Prostatitis

2 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE

Wilmer C. Ensor M.D.

M. D. or other

Address Cockeysville Md

Date signed 2/23/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 26 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 596

CERTIFICATE OF DEATH

Reg. Dist. No. 01394 53

1. PLACE OF DEATH:

County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 Butler Road
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Florence Amelia Naylor

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Widowed</u>

6.(b) Name of husband or wife James T. Naylor

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1866

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>10</u>	<u>20</u>hrs.min.

9. Birthplace Baltimore City
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Allman13. Birthplace ValesMOTHER 14. Maiden name Martha McClure15. Birthplace Baltimore City18. Informant Mary N. NaylorAddress Reisterstown, Md.11. Burial Date thereof Feb. 8, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory All-SaintsLocation Balto. Co.16. Funeral director J.F. Eline & SonsAddress Reisterstown, Md.19. 2-8 1946 Dary B. Eline

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1946 at 11 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-7 1936 to Feb 5 1946and that I last saw her alive on Feb 5 1946

Immediate cause of death

Myocarditis
Chronic Angina
Hypertrophic Arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE D. D. Eagles, M.D. M. D. or otherAddress Reisterstown, Md. Date signed 2-6-46

Address

Date signed

Date signed

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 64

RECEIVED
FEB 12 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

Reg. Dist. No. 01395

FILM No. 100 FEB 18 1946

1. PLACE OF DEATH

County... Baltimore
City or town... Towson, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since July 14, 1945

Hospital, Institution, or street address where death occurred
Dudowood Sanatorium, Towson 4, Md.

How long in hospital or Institution? Since July 14, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Worcester

City or town... Pocomoke City

Street No... R 7 5 # 3

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Doris Outten

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Para P Outten

7. Birth date of

deceased (mo., day, yr.)

December 25, 1890 1894

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

57

2

hrs.

min.

9. Birthplace

Worcester County, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Samuel Blaze

13. Birthplace

Goodwill, Md.

14. Maiden name

Eleanor Vessey

15. Birthplace

Goodwill, Md.

16. Informant

Personal History Hospital Records

Address

Dudowood Sanatorium Towson 4, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb 9/46

Cemetery or crematory

Pocomoke Md.

Location

18. Funeral director

Dennis & Watson

Address

Pocomoke Md.

19.

2/9 19 46

a.w. Hedrick

Registral

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 7 1946 at 8:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 14 1945 to February 7 1946

and that I last saw... alive on February 7 1946

Immediate cause of death

Pulmonary tuberculosis

DURATION

Since 1943

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William A Bridges

M. D. or other

Address

Towson, Maryland

Date signed 2-7-46

MAINTAINING STATE OF MENTAL HEALTH

STATE OF MENTAL HEALTH

2/19/46

MARGINAL STATE HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 38

1. PLACE OF DEATH:

- (a) Baltimore Co. Maryland
- (b) Street address Register Ave. Sherwood Rd
- (c) ~~Hospital or institution~~
Armaeost Nursing Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days) _____
- (e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:

- (a) State md (b) County Baltimore
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 1813 East 33rd St
(If rural give location) ✓
- (e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3 (a) FULL NAME

- William A. Parr
- 3 (b) If veteran, name war _____
- 3 (c) Social Security Account No. _____

- | | | |
|-----------------------|----------------------------------|---|
| 4. Sex
<u>Male</u> | 5. Color or race
<u>White</u> | 6 (a) Single, married, widowed, or divorced
<u>Widowed</u> |
|-----------------------|----------------------------------|---|
- 6 (b) Name of husband or wife Theresa A. Parr
- 6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar 10th 1867
- | | | | |
|----------------------------|---------------------|-------------------|--|
| 8. AGE: Years
<u>78</u> | Months
<u>11</u> | Days
<u>13</u> | If less than one day
hr. _____ min. _____ |
|----------------------------|---------------------|-------------------|--|

9. Birthplace Balto md.
(Town, county, and state)
10. Usual Occupation Building Engineer
11. Industry or business City of Balto.

- | | |
|--------|---|
| FATHER | 12. Name <u>John M. Parr</u> |
| | 13. Birthplace <u>England</u> |
| MOTHER | 14. Maiden Name <u>Catherine Shelby</u> |
| | 15. Birthplace <u>Germany</u> |

- 16 (a) Informant Mrs T. F. Manley
- (b) Address 1813 E. 33rd St.
- 17 (a) Burial (b) Date thereof 2/27/46
(Burial, exhumation, or removal) (month) (day) (year)
- (c) Cemetery or crematory Parkwood
Location Parkville Md.

- 18 (a) Funeral director William Cook Inc.
- (b) Address 1217 St. Paul St.
- 19 (a) 2/26/46 (b) A. W. Hedrick
(Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/46 1946, at 10⁴⁵ AM
21. I certify that death occurred on the date above stated; that I attended deceased from July 1928, to 2/23 1946, and that I last saw him alive on 2/23 1946.

- Immediate cause of death Cerebral Hemorrhage
- Due to Arterio Sclerosis
- Due to Hypertension

- Other Conditions _____
- (Include pregnancy within 3 months of death)
- Date of operation _____
- Major findings of operation: _____

- of autopsy _____
22. If death was due to external causes, fill in the following:
- (a) Accident, suicide, or homicide _____
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

- (e) Means of injury M.H. Ready
23. Signature M.H. Ready M.D.
- Address 1403 Park Ave Date signed 2/23/46

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B.D.

CERTIFICATE OF DEATH

Reg. Dist. No. 01347

1. PLACE OF DEATH:

County Baltimore

City or town Beckleyville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Beckleyville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel T. Patterson

3. (b) Social Security Number

✓

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of ~~widow~~ or wife Florence E. V. Patterson

7. Birth date of deceased (mo., day, yr.) unknown 6.(c) If alive, give age years

8. AGE: Years about 78 Months Days If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business "

FATHER 12. Name Julius Patterson
13. Birthplace md

MOTHER 14. Maiden name Susan Baublitz
15. Birthplace md

16. Informant Clemence Baublitz
Address Hampstead Md. R.D.

17. Burial Date thereof Feb 6/46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Beckleyville
Bald & Co Md
Location

18. Funeral director Edw Tipton
Address Hampstead Md

19. Feb. 5- 19 46 Quil E. Fowler M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 19 46 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1936 to Feb 4 1946
and that I last saw him Jan. 2 1946 alive on

Immediate cause of death arterio-sclerotic cardio-vascular disease

DURATION

7 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice C. Partin
Hampstead, Md M. D. or other 2-5-46
Address: Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 7 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 01398

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution; or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

John Curtis Pearson?

3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

8. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Transportation.....

(Burial, cremation, or removal. Which?).....

Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from.....

and that I last saw him..... alive on.....

Immediate cause of death.....

DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

(City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Address.....

Date signed.....

RECEIVED
SEP 25 1946
BUREAU V.B.

OFFICE HOURS:

9 TO 10 A. M.

7 TO 8 P. M.

SUNDAY BY APPOINTMENT

REG. NO. 4622

DR. GEO. S. M. KIEFFER

BALTIMORE, MD.

OFFICE

2470 WASHINGTON BLVD.

RESIDENCE

1010 LEEDS AVENUE

DATE

July 1, 46

FOR

ADDRESS

R

*Complete
data not
known at
present time. under
investigation*

*Geo. S. M. Kieffer
Kieffer Medical Bureau*

Evidence for change of year of birth of deceased is shown **MARYLAND STATE DEPARTMENT OF HEALTH**
2411 N. Charles St., Baltimore

FILM No. I 00 MAR 6 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore
City or town Baltimore 24
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 months
Hospital, institution, or street address where death occurred:
5601 Crosshill Ct.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore 24
(If outside city or town limits, write RURAL and give nearest town)
Street No. 921 Bay Street
(If rural, give LOCATION)
2(a) If veteran, name war —

3. (a) FULL NAME

Mrs. Bertha Pittman

3. (b) Social Security Number

4. Sex F 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband Ulysses Pittman
6. (c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.) December 27, 1910 1909
8. AGE: Years 36 Months 1 Days 14 If less than one day — hrs. — min.

9. Birthplace Mad County North Carolina
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

12. Name Basil Coley
13. Birthplace North Carolina

14. Maiden name —
15. Birthplace North Carolina

16. Informant Ulysses Pittman
Address 5601 Crosshill Ct.

17. Burial Date thereof Feb. 14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory mt Calvary Cemetery
Location A A County

18. Funeral director Mrs. Robert A. Elliott & Daughter
Address 1129 N. Caroline St.

19. 2/14 19 46 Registrar —
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 19 46 at 8:30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11, 1946 19 46 to Feb 11 19 46
and that I last saw him — alive on — 19 —
Immediate cause of death Bronchial Pneumonia

Other conditions —
(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —
23. SIGNATURE William C. Webb, M.D. M. D. or other —
Address 140 Oak Ave Dundalk Md. Date signed 2-11-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 01400

1. PLACE OF DEATH:

County BaltimoreCity or town Perry Hall
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John J Polesne

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Perry Hall
(If outside city or town limits, write RURAL and give nearest town)Street No. Cross Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Anna Skalobae7. Birth date of deceased (mo., day, yr.) Year 1866
6. (c) If alive, give age _____ years

8. AGE:

80

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace Czecho Slovakia
(Town, county, and state)10. Usual occupation Poultry raiser

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

"

MOTHER

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

James Polesne

Address

Cross Road

17.

Burial Date thereof 2/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Belair Road

18. Funeral director

Lazarus Funeral Home

Address

7401 Belair Road

19.

Feb 12 19 46 W. M. Hemmett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946 9.30 AM at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29th 19 45, to Feb 11 19 46and that I last saw him alive on Feb 11th 19 46

Immediate cause of death

Myocardial insufficiency

DURATION

3 daysDue to Arteriosclerosis years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

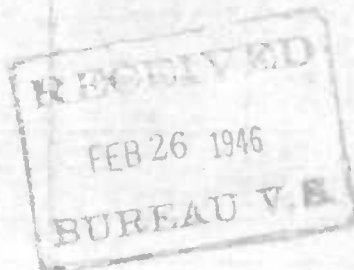
Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. L. WilkinsonA. L. Wilkinson, M.D. D. or otherAddress 5713 Bel Air Rd. Date signed 2-11-46

L. A. L. Wilkinson
5713 Belair Rd



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33a

CERTIFICATE OF DEATH

Reg. Diat. No. 01401 32

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)Street No. 113 Sherwood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

NORMAN S. POWELL Sr

3.(b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Francis W. Powell

7. Birth date of deceased (mo., day, yr.)

11/3/18706.(c) If alive, give age 67 years

8. AGE:

Years

75

Months

2

Days

1

If less than one day

hrs.

min.

9. Birthplace

Big Furnace, Maryland
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

FATHER

MOTHER

12. Name

Sidney Powell

13. Birthplace

Pocomoke, Maryland

14. Maiden name

Ethel Ellis

15. Birthplace

Franklin City, Maryland

16. Informant

Norman S. Powell Jr.

Address

113 Sherwood Ave. Pikesville, Md.

17. Burial, cremation, or removal. Which?

Reinterment

Date thereof

Feb 6, 1946
(month) (day) (year)

Cemetery or crematory

London Park

Location

Friedrich Rd. Baltimore, Maryland

18. Funeral director

Frank H. Powell

Address

Pikesville, Maryland

19. Date rec'd by registrar

2-5-

19.46

E. E. Nichols

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 4 19. 46 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 - 19. 43, to Feb 4 19. 46and that I last saw him alive on Feb 4 - 19. 46

Immediate cause of death

Cerebral hemorrhage

DURATION

2 1/2 hrs.

Due to

arterial hypertension2

Due to

arterial sclerosis2

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. E. Nichols

M. D. or other

Address

Pikesville & Md.Date signed Feb 5 - 46

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED
FEB 8 1946
BUREAU T R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0144

1. PLACE OF DEATH:

County BaltimoreCity or town Jones Creek, Sparrows Point-19, Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 58 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Rigling

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Isabelle Rigling

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 18878. AGE: Years Months Days If less than one day
58 8 17 hrs. min.9. Birthplace Harrisburg, Pa.
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name Joseph Rigling13. Birthplace Pa.14. Maiden name Mary Mark15. Birthplace Penna.16. Informant Mrs. Isabelle RiglingAddress 2206 Lincoln Ave. 1917. Burial Date thereof Feb 23-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Park Lawn CemLocation City18. Funeral director Wesley Funeral HomeAddress 2008 Orleans St19. Feb 21 19 46
(Date rec'd by registrar)W. H. H. H. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1946 19 at 12:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1945 to February 1946
and that I last saw him alive on Feb. 19 19 1946Immediate cause of death Coronary occlusion

DURATION

1 dayDue to Coronary artery disease1 year

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. H. H. H. H. M. D. or otherAddress 520 W St. Sparrows Point, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 123

CERTIFICATE OF DEATH

01403

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 weeks

Hospital, institution, or street address where death occurred:

Harlem LodgeHow long in hospital or institution? 18 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)Street No. 3811 Hadley Square East
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

GRACE WOOLFORD ROBERTS

3. (b) Social Security Number

4. Sex

Female White

5. Color or race

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife William H. Roberts

7. Birth date of

deceased (mo., day, yr.)

Oct. 12, 1873

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7243

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name William Woolford13. Birthplace Dorchester Co. Md.

MOTHER

14. Maiden name Mary Williams15. Birthplace Md.16. Informant Mrs. William Paul DayAddress 3811 Hadley Square, East17. Burial
(Burial, cremation, or removal, Which?)Date thereof 2/18/46
(month) (day) (year)Cemetery or crematory Druid Ridge Cem.Pikesville, Md.

Location

18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 2/18 19 46 A. W. Hedrick
(Date reg'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 19 46 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 8 19 45 to Feb 13 19 46
and that I last saw him alive on February 15 19 46

Immediate cause of death

Circulatory collapse

DURATION

1 hourDue to Fallowing incision and
drainage of abdominal abscess9 daysDue to Divericulitis11 daysOther conditions Generalized arteriosclerosis
Smile Psychosis
(Include pregnancy within 3 months of death)2
6 mos

Major findings of operations

Abdominal Abscess
Divericulitis - ruptured Date of op. Feb 13, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur J. Mitchell, M.D. M. D. or otherAddress Harlem Lodge Date signed FEB 15 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: County... <u>Baltimore</u> City or town... <u>608 Edmondson Ave. Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>74 yrs</u> Hospital, institution, or street address where death occurred: <u>608 Edmondson Ave. Catonsville</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Maryland</u> County... <u>Baltimore</u> City or town... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>608 Edmondson Ave</u> (If rural, give LOCATION) 2. (a) If veteran, name war			
3. (a) FULL NAME <u>Frank Charles Ruff</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Male</u> 5. Color or race <u>White</u> 6. (a) Single, married, widowed, or divorced <u>Married</u> B. (b) Name of husband or wife <u>Rosalie Ruff</u> <u>NEE Miles</u> 6. (c) If alive, give age <u>66</u> years 7. Birth date of deceased (mo., day, yr.) <u>Dec. 12, 1871</u>				MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Feb 16, 1946</u> at <u>9:45</u> AM 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>19</u> to <u>19</u> and that I last saw h... alive on <u>19</u> Immediate cause of death <u>Coronary occlusion</u> <u>Sudden death</u> Other conditions <u>Imping</u> (Include pregnancy within 8 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
8. AGE: Years <u>74</u> Months <u>2</u> Days <u>4</u> If less than one day <u>hrs. min.</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
9. Birthplace <u>Catonsville, Balto., Co. Md.</u> (Town, county, and state) 10. Usual occupation <u>Operator Filling Station (Owned personally)</u> 11. Industry or business				12. Name <u>Frank Ruff</u> 13. Birthplace <u>Unknown</u> 14. Maiden name <u>Virginia</u> ? 15. Birthplace <u>Unknown</u>			
16. Informant <u>Mrs. Rosalie Ruff</u> Address <u>608 Edmondson Ave. Catonsville</u>				17. Burial (Burial, cremation, or removal? Which?) <u>Burial</u> Date thereof <u>Feb 19 1946</u> (month) (day) (year) Cemetery or crematory <u>Salem Lutheran</u> Location <u>Ingleside Ave. Catonsville</u> <u>Eastern Home</u>			
18. Funeral director <u>Eastern Home</u> Address <u>608 Frederick Ave. Catonsville</u>				19. 2-18 <u>46</u> <u>Harold Miller</u> (Date rec'd by registrar) (month) (day) (year) Registrar			
23. SIGNATURE <u>Dr. J. M. Kieffer</u> Address <u>1010 Leek Ave</u> Date signed <u>2-16-46</u>				M. D. Registrar			

RECEIVED
FEB 21 1946
BUREAU T B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *242*

CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 211 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, MarylandHow long in hospital or institution? 211 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town 637 S. Streepier, Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. See above
(If rural, give LOCATION)2. (a) If veteran, name war WW-I

3. (a) FULL NAME

JOHN RYDZYNSKI

3. (b) Social Security Number

216-09-9251

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
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6. (b) Name of husband or wife Single

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 7-27-89

8. AGE:	Years	Months	Days	If less than one day
<u>58</u>	<u>6</u>	<u>23</u>	_____ hrs.	_____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Clerk

11. Industry or business

12. Name John Rydzynski13. Birthplace Warsaw14. Maiden name Mary ?15. Birthplace Warsaw16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland17. Burial Date thereof FEB. 15 46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. StanislawLocation Dundalk Ave18. Funeral director Stephen J. ZialowskineAddress 1000 South Kenwood Ave19. Feb. 23 46 A. W. Hedrick
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 19 46, at 5:00 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1945 to Feb. 20, 1946and that I last saw him alive on February 20, 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to Arteriosclerosis, generalized Unknown

Due to

Other conditions Cirrhosis of liver withascites

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Balter
A. M. BALTER, LT. COL., M. O. DIST. DIR.Address PK Ft. Howard, Md. Date signed 2-21-46

FEB 23 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (480)

CERTIFICATE OF DEATH

Reg. Dist. No. 0140647

1. PLACE OF DEATH:
 County Baltimore
 City or town Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Chesaco Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Margaret V Schatzschneider

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Charles Schatzschneider
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) July 26 1860
 8. AGE: Years 85 Months 6 Days 18 If less than one day
 hrs. min.

9. Birthplace Baltimore County
 (Town, county, and state)
 10. Usual occupation At Home
 11. Industry or business
 12. Name Casper Erisbey
 13. Birthplace Germany
 14. Maiden name Katherina Hofstetter
 15. Birthplace Germany

18. Informant Charles Schatzschneider
 Address Chesaco Ave Raspeburg
 Burial 2/16/46
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Zion Lutheran
 Location Stemmers Run
 18. Funeral director Lassahn Funeral Home
 Address 7401 Belair Road
 19. 2/18 46 John S. Connelly
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

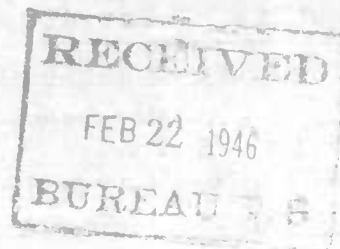
20. DATE OF DEATH Feb 13 1946 6.40 PM, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to Feb 13 1946
 and that I last saw h. or alive on Feb 13 1946
 Immediate cause of death Toxemia

Other conditions Arterio Sclerotic Cardio Vascular Disease
 (Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statitically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE John S. Connelly M. D. or other
 Address Balt 6 Date signed 2-14-46

Dr. Baumgardner



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)Street No. Schultz Lane Route 16 # 102

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frederick W Schultz

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Lydia C Schultz7. Birth date of deceased (mo., day, yr.) Nov 8 1862 6. (c) If alive, give age _____ years8. AGE: Years 83 Months 2 Days 30 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore County
(Town, county, and state)10. Usual occupation Truck Farmer

11. Industry or business

12. Name Christian J. Schultz13. Birthplace Germany14. Maiden name Unknown15. Birthplace Germany16. Informant Mrs Frederick W SchultzAddress Schultz Lane Route 16 # 10217. Burial Burial Date thereof 2/9/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ImmanuelLocation Grindon Ave18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Road19. 2-2- 19 46 John G. Connolly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/46 5.30 AM 19____ at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to 2/4 1944
and that I last saw him alive on 2/16/46 19____

Immediate cause of death

Frigitella nalaria
Cerebral arteriosclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John G. Connolly M. D. or otherAddress Ray, Md. Baltimore - 6 Date signed 2/7/46

CERTIFICATE OF DEATH

Dr. J. L. L. L.
Ridge Road

REC'D
FEB 13 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltimoreCity or town Relay
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 mo

Hospital, institution, or street address where death occurred:

1704 Glover St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Relay
(If outside city or town limits, write RURAL and give nearest town)Street No. 1704 Glover St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Sallie Spriggs Schulz

3.(b) Social Security Number

none4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married9.(b) Name of husband or wife Frank E. Schulz7. Birth date of deceased (mo., day, yr.) Apr 27 - 1891 6.(c) If alive, give age 53 years8. AGE: Years 54 Months 9 Days 26 It less than one day hrs. min.9. Birthplace Baltimore City
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Domestic12. Name William Henry Birkett13. Birthplace Baltimore City, Md14. Maiden name Willie Blanche Mason15. Birthplace Baltimore City, Md16. Informant Hurdan SchulzAddress 43 Wheeler Ave, Baltimore Md17. Burial Date thereof Feb 27, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Louaine ParkLocation Woodlawn Md18. Funeral director Mrs. Mrs. John H. Tengel & SonAddress 801 W. Fayette St.19. 2/26 1946 F. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1946 at 8:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 1946 to Feb 24 1946and that I last saw him alive on Feb 24 1946

Immediate cause of death

Cerebral DURATION 3 da.Due to arterial hypertension ?chr. myocarditis ?Due to Left Heart Failure 2 yrsOther conditions (History)

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: It death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. B. Brumbaugh M. D. or otherAddress 809 Main St Date signed 2/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, Md.How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1046 N. Broadway,
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

3. (a) FULL NAME

HOWARD E. SEABREASE

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
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6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-19-1892

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>1</u>	<u>1</u>	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Huckster

11. Industry or business

12. Name Harry Seabrease13. Birthplace Maryland14. Maiden name Emma Rodgers15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hosp.
Address Ft. Howard, Md.17. Burial Date thereof Feb. 23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland18. Funeral director A. Lee Oder
Address 4644 York Road., Balto., Md.19. Feb. 23 46. A.W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 19 46, at 12:15 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 19 46, to February 20, 19 46, and that I last saw him alive on February 20, 19 46.Immediate cause of death Bronchogenic Carcinoma DURATION Unknown

Due to

Due to

Other conditions Broncho-pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Bronchogenic Carcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.M. Balter
A. M. BALTER, LT. COL., M.C.M. BATTAL DIR.
Address Ft. Howard, Md. Date signed 2-20-46

FEB 28 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and accurately.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1910

CERTIFICATE OF DEATH

01410

Reg. Diat. No. 424

1. PLACE OF DEATH:

County Baltimore Co.City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Samuel A. Simmons

3. (b) Social Security Number

213-07-1958

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 23, 1895

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

504

_____ hrs.

_____ min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Foreman

11. Industry or business

Bethlehem Steel

FATHER

12. Name

Adam Simmons

13. Birthplace

Pennsylvania

MOTHER

14. Maiden name

Nancy Gallagher

15. Birthplace

Pennsylvania

16. Informant

Mr. Raymond E. Johnson

Address

523 E. St. Sparrows Point

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/22/46
(month) (day) (year)

Cemetery or crematory

Steelton Cem.

Location

Steelton Pa.

18. Funeral director

John F. Hennig, Inc., Carl F. Chess

Address

715 Light St.

19. Feb. 22, 1946

(Date rec'd by registrar)

A. H. Hedrick
per A.E.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20th 19 46 at 1¹⁵ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 19, 45 to Feb. 20, 46and that I last saw him alive on February 19, 46

Immediate cause of death

Hyper-tension & atherosclerosis
cardiovascular disease

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. J. D. ...
M. D. or other

Address

5200 St. ...Date signed 2-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Dist. No. 0141144

1. PLACE OF DEATH:

County BaltimoreCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County ---City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1430 N. Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert Herman Sindorf

3. (b) Social Security Number

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Florence H. Sindorf6. (c) If alive, give age 46 years

7. Birth date of

deceased (mo., day, yr.) Apr. 8 - 1899

8. AGE:

Years 46Months 10Days 8

If less than one day

hrs. min.

9. Birthplace Pa

(Town, county, and state)

10. Usual occupation Flight Controller11. Industry or business Sherrin & Martin Co.

FATHER

12. Name Albert H. Sindorf13. Birthplace Pa

MOTHER

14. Maiden name Mary Guthrie15. Birthplace Pa16. Informant Florence H. SindorfAddress 1430 N. Broadway17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2-10-46

(month) (day) (year)

Cemetery or crematorium Luthersburg CemeteryLocation Luthersburg Pa18. Funeral director Wendell E. HumphreysAddress 6067 Harford Rd19. 2/17/46

(Date recd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 - 1946 at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46and that I last saw him alive on 19 46

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? Baltimore
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wendell E. HumphreysAddress 6067 Harford RdDate signed 2/17/46

RECEIVED

FEB 21 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Alessi
6217 Harford Rd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01412

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baltimore

City or town Carmey
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3rd Ave Carmey - Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Carmey
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3rd Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Annie Smith

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Married

6.(b) Name of husband or wife Edward B

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1899

8. AGE: Years Months Days If less than one day
46 6 6 hrs. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name George W. Hansen

13. Birthplace Va.

14. Maiden name Frances Savin

15. Birthplace Laurens Co. Va.

16. Informant Mr Edward B. Smith

Address 3rd Ave Carmey Md

17. Buried Date thereof Feb 5 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Moreland Park

Location Baltimore

18. Funeral director L. J. Rock

Address 5305 Harford Rd

19. 2-5 46 Am Med
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1946, at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1943 to Feb. 3 1946

and that I last saw h. er alive on Feb 3 1946

Immediate cause of death

Sarcinatosi

Due to Sarcinatosi

Due to Sarcinatosi

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Sarcinatosi Date of op. 4/1/43

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. A. Alessi M.D.

Address 6217 Harford Rd Date signed 2-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98d)

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 years
 Hospital, institution, or street address where death occurred:
Reisterstown Rd
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Reisterstown Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

George Washington Smith

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M
 6. (b) Name of husband or wife Hannah Dudley Smith
 6. (c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) June 27 1875
 8. AGE: Years 70 Months 7 Days 7 If less than one day
hrs.min.

9. Birthplace Baltimore Md
 (Town, county, and state)
 10. Usual occupation Cake Salesman
 11. Industry or business -
 12. Name Charles Smith
 13. Birthplace Baltimore Md
 14. Maiden name Sarah Neal
 15. Birthplace Baltimore Md

16. Informant Mrs Hannah D Smith
 Address Reisterstown Md
 17. Burial Date thereof Feb 7 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lorraine Cemetery
 Location Baltimore Md
 18. Funeral director Wm Berryman & Sons
 Address Reisterstown Md
 19. 2-6 1946 Mary B. E. Lins
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4th 19 46, at 8 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
JANUARY 19 41, to FEB 4th 19 46
 and that I last saw him alive on JAN. 24 19 46
 Immediate cause of death Chronic Myocarditis DURATION 1 yr
Coronary Sclerosis 2 yrs
Art. Sclerosis 2 yrs
 Other conditions Hypertension 5 yrs
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE James F. Miller, M.D. M. D. or other
Pikesville - 8, Md Address..... Date signed 2/6/46

CERTIFICATE OF DEATH

RECEIVED

FEB 8 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11414 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 months, 27 days
 Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 3 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel
 City or town..... Eastport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 317 First Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3.(a) FULL NAME

Julia Smith

3.(b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... Robert Smith
 7. Birth date of deceased (mo., day, yr.)..... August 14, 1868 6.(c) If alive, give age..... years
 8. AGE: Years..... 77 Months..... 5 Days..... 12 If less than one day..... hrs. min.

9. Birthplace..... West River, Maryland
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business..... Home
 12. Name..... James Proctor
 13. Birthplace..... Maryland
 14. Maiden name..... Harriet ? Lee
 15. Birthplace..... Maryland

16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland
 17. Burial Date thereof..... 2/8/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....
 Location..... Annapolis Md.
 18. Funeral director..... E. Miller Lane
 Address..... 1003 W. Baltimore St.
 19. 2-6- 19. 46 Harry D. Miller
 (Date rec'd by registrar) (month) (day) (year) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 5 19. 46 at 3:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 9 19. 45 to February 5 19. 46
 and that I last saw her alive on February 5 19. 46

Immediate cause of death..... Chronic myocarditis DURATION..... indef.
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results..... None
 PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE..... Isadore Tuerk, M.D. M. D. or other
 Address..... Catonsville-28, Md. Date signed..... 2-5-46

RECEIVED
FEB 8 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

014150

1. PLACE OF DEATH

County Baltimore

City or town Hydco Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Hydco
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Alfred J. Smithwick

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Emma M. Smithwick

7. Birth date of deceased (mo., day, yr.)

Aug 25 - 1879

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

66

5

29

hrs.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Horse Dealer

FATHER

12. Name

Alfred Smithwick

13. Birthplace

Ireland

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Emma M. Smithwick

Address

Hydco Md.

17.

(Burial, cremation, or removal. Which?)

Cremation

Date thereof

Feb 25 - 1946

(month) (day) (year)

Cemetery or crematory

London Park Cem.

Location

Fredrick Ave Balto Md.

18. Funeral director

Clarence E. Arthur

Address

Fork Md.

19.

Feb. 24

19

46

Clarence E. Arthur

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 23 1946 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12, 1945 to Feb 23, 1946

and that I last saw him Feb 22, 1946 alive on _____

Immediate cause of death

Coronary Thrombosis DURATION 20 min.

Due to

Coronary Sclerotic Heart Disease 4 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

Clifford F. Yudson, M.D.

23. SIGNATURE

M. D. or other

Fork, Md. Date signed 2/24/46

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

RECEIVED
MAR 1 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: Balto. Co.
 County Optiz Home
 City or town Chesapeake
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3054 Brighton St.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME Mary Magdalene Sommer 3. (b) Social Security Number 4

4. Sex Female 5. Color or race W 6. (a) Single, married, wid, wed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) May 22 1858
 8. AGE: Years 87 Months Days If less than one day
 hrs. min.

9. Birthplace Harford County
 (Town, county, and state)
 10. Usual occupation
 11. Industry or business

12. Name Wm Sommer
 13. Birthplace Germany
 14. Maiden name Emilie
 15. Birthplace Germany

16. Informant Joe Sommer
 Address 3054 Brighton St
 17. Burial Date there Feb 18-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St Paul Cem
 Location Hq Wilkens Co.
 18. Funeral director Hq Rohde & Son
 Address 2327 Edmondson Ave

19. 2/18 19 46 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 19 46 at 4 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 46 to Feb 15 19 46
 and that I last saw him alive on Feb 14 19 46

Immediate cause of death Cerebral Hemorrhage DURATION 4 days

Due to Cerebral Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Brown M. D. or other 7/17
 Address Cotonsville Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (952)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

4308 Kensington Rd.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No. 4308 Kensington Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Ella Spink

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

8.(b) Name of husband or wife.....Samuel

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)
April 8, 1865

8. AGE: Years Months Days It less than one day

80

9

23

.....hrs.min.

9. Birthplace.....Baltimore, Md.
(Town, county, and state)10. Usual occupation.....At Home

11. Industry or business

12. Name.....Adam Seifert13. Birthplace.....Germany

14. Maiden name

15. Birthplace.....Unknown16. Informant.....Mr. Charles H. SchanfelterAddress.....4308 Kensington Rd.17. Burial Date thereof.....2/4/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory.....Loudon Park Cemt.Location.....Frederick Rd.18. Funeral director.....William J. Tichner & SonsAddress.....North & Pa. Aves.19. 2/4 19 46 Coupled
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 1, 19 46, at 1052 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 19 45 to February 1, 19 46
and that I last saw h. 22 alive on Febr 1, 19 46

Immediate cause of death..... DURATION

Cardio Vascular Degenerative Dis. 2 yrs.

Due to.....

Due to.....

Other conditions.....Curculor Fibrillation 1 yr.Acidosis 3 days
(Include pregnancy within 3 months of death)Major findings of operations.....none

Date of op.

Autopsy results.....none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....Earl Pass, M.D. M. D. or otherAddress.....4001 Wilkens Ave Date signed.....2-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

01418

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, MarylandHow long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #2
(If rural, give LOCATION)2.(a) If veteran, name war SAW

3. (a) FULL NAME

CHARLES E. STEVENS

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Alice Stevens6. (c) If alive, give age 57 years7. Birth date of deceased (mo., day, yr.) 5-26-74

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>9</u>	<u>1</u> hrs. min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Jim Stevens13. Birthplace Virginia14. Maiden name Lizzie Linkenhoker15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.
Address Ft. Howard, Maryland17. Burial Date thereof Mar. 1-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Aberdeen MdLocation Aberdeen Md18. Funeral director Henry Tarrington SonsAddress Aberdeen Md19. Feb 27 46 A. M. Balter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1946 at 6:15 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23, 1946 to February 27, 1946and that I last saw him alive on February 27, 1946

Immediate cause of death

HEART DISEASE,Coronary Arteriosclerosis,xxx cardiac enlargement, myocardial
insufficiency, auricular fibrillation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Balter
A. M. BALTER, LT.COL., M.C. CLIN.DIR.Address Ft. Howard, Md. Date signed 2-27-46DURATION
9-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 1 mo., 1 day
 Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution? 0 yrs., 1 mo., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3930 Yolando Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Dorothy Stoffregen

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... John Stoffregen
 6.(c) If alive, give age..... 41 years
 7. Birth date of deceased (mo., day, yr.)..... December 13, 1907
 8. AGE: Years..... 38 Months..... 1 Days..... 23 If less than one day..... hrs. min.

9. Birthplace..... Brunswick, Maryland
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....

MOTHER FATHER
 12. Name..... Edward Richards
 13. Birthplace..... Hancock, Maryland
 14. Maiden name..... Daisy Porter
 15. Birthplace..... Knoxville, Maryland

16. Informant..... Mrs. Dorothy Stoffregen
 Address..... 3930 Yolando Rd., Balto., Md.

17. Burial..... Burial Date thereof..... Feb. 8, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Lorraine Cemetery
 Location..... 5608 Dogwood Rd., Woodlawn, Md.

18. Funeral director..... John A. Moran
 Address..... 3000 E. Balto. St., Balto., Md.

19. Feb. 5, 1946 Earl Webster
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 5, 1946, at 1:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 4, 1946, to Feb. 5, 1946
 and that I last saw her alive on February 5, 1946

Immediate cause of death..... Pulmonary Tuberculosis
 DURATION
3 yrs.
9 mos.

Due to..... Tubercle Bacilli

Due to.....

Other conditions..... Tuberculous Laryngitis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations..... No operation

Date of op.

Autopsy results..... No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Stewart A. Shaffer M.D.

M. or other

Address..... Mount Wilson, Md. Date signed..... 2/5/46

RECEIVED
FEB 9 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 01420 44

1. PLACE OF DEATH

Baltimore
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md. County Balto.
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Edgemere
Street No. 6801 North Point Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Charles C. Strasbaugh

3. (b) Social Security Number

213-07-0197

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Emma C. Strasbaugh

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) July 13th. 1885

8. AGE: Years 60 Months 6 Days 25 If less than one day..... hrs. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation Retired Heater

11. Industry or business Bethlehem Steel Co. Sparrows Pt.

12. Name John Strasbaugh

13. Birthplace Pa.

14. Maiden name Emma Cook

15. Birthplace Pa.

16. Informant Mrs. Emma C. Strasbaugh

Address 6801 North Point Rd.

Burial Date thereof Feb. 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cem.

Location Balto., Md.

16. Funeral director Philip Henrich Sons

Address 2024 Orleans St.

19. 2/11/46 46 Registrar
(Date rec'd by registrar) 19.....

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9th. 1946 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1945 to Feb 9 1946
and that I last saw him on Feb 6 1946

Immediate cause of death Hypertensive and Atherosclerotic Cardiovascular Disease

DURATION

Due to disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address 5201 H St. N.D. Date signed 2-11-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No.

01421

Y

1. PLACE OF DEATH:
County..... Baltimore
City or town..... Brooklandville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 74 Years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Baltimore
City or town..... Brooklandville
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Hillstead Farms
(If rural, give LOCATION)
.....
2.(a) If veteran, name war.....

3. (a) FULL NAME
Isaac Lobe Straus
3. (b) Social Security Number

4. Sex..... Male
5. Color or race..... White
6. (a) Single, married, widowed, or divorced..... Widowed
6. (b) Name of husband or wife..... Florence Ridgely
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... March 24, 1871
8. AGE: Years..... 74 Months..... 10 Days..... 10 It less than one day..... hrs. min.

9. Birthplace..... Baltimore, Maryland
(Town, county, and state)
10. Usual occupation..... Attorney
11. Industry or business.....
12. Name..... William Henry Straus
13. Birthplace..... Baltimore, Md.
14. Maiden name..... Annette Lobe
15. Birthplace..... Baltimore, Md.

16. Informant..... Henry L. Straus
Address..... Reisterstown, Md.
17. Burial Date thereof..... 2/7/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Har Sinai
Location..... Baltimore, Md.
18. Funeral director..... W. B. Weeks and Son
Address..... 805 N. Calvert Street

19. 2-6 19 46 W. B. Weeks
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 4 19 46 at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to Feb 4 1946
and that I last saw him alive on Feb 13 19 46

Immediate cause of death.....
General Senile Deterioration
Arterio Sclerosis
Cellulitis - Left Leg
Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)
Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?
23. SIGNATURE..... William H. Baker
M. D. or other
Address..... 1115 15th Street SE Date signed..... 2/6/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1422

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 3d
 Village or City Catonsville No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME Ione Jackson Stuart

If U. S. Veteran, specify WAR _____

(a) Residence: No. 39 W. Preston St.

St. _____ Ward _____

Baltimore, Md.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>		
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of <u>Richard D. Stuart</u>				
6. DATE OF BIRTH (month, day, and year) <u>July 6, 1858</u>				
7. AGE Years <u>87</u>	Months <u>7</u>	Days <u>1</u>	If LESS than 1 day, _____ hrs. or _____ min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>seamstress</u>			
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>retired</u>			
	10. Date deceased last worked at this occupation (month end year) _____		11. Total time (years) spent in this occupation _____	

12. BIRTHPLACE (city or town) Cecil County, Md.
 (State or country)

13. NAME Phillip F. Jackson

14. BIRTHPLACE (city or town) Cecil County, Md.
 (State or country)

15. MAIDEN NAME Amelia S. Owens

16. BIRTHPLACE (city or town) Cecil County, Md.
 (State or country)

17. INFORMANT Mrs. Edna M. Bollman
 (Address) 1825 N. Forest Park Ave., Balto.

18. BURIAL, CREMATION, OR REMOVAL
 Place Loudon Park Cem'ty Date 2/9/46, 19____

19. UNDERTAKER John O. Mitchell & Sons, Inc.
 (Address) 1900 Eutaw Place, Balto., Md.

20. FILED 2-9-46 Harry H. Miller
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February7

(Month)

(Day)

1934

(Year)

22. I HEREBY CERTIFY, That I attended deceased from

Nov. 1, 1945, to Feb 7, 1946I last saw him alive on Feb 7, 1946, death is saidto have occurred on the date stated above, at 6 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Myocarditis
Generalized arteriosclerosis

Date of onset

??

Other Contributory Causes of Importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOL ENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) _____

(Address) _____

M. D.

2-8-46

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
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Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

01423 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 30 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County _____
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box #283
(If rural, give LOCATION)
2. (a) If veteran, name war WW-I

3. (a) FULL NAME
JOSEPH M. THOMAS

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife _____
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) 4-24-92
8. AGE: Years 53 Months 9 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Janitor
11. Industry or business _____
12. Name Robert Thomas
13. Birthplace Maryland
14. Maiden name Fannie Wooden
15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof 18 Feb - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
Location _____

18. Funeral director A. Lee Oder
Address 4644 York Road., Balto., Md.

19. 2/16 19 46
(To be filled by registrar) Registrar A. N. Dehich

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 46 6:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 15, 19 46 to February 14, 19 46
and that I last saw him alive on February 14, 1946

Immediate cause of death
Tuberculosis, chr. pul. far adv.
active

DURATION

Unknown

Due to _____

Due to _____

Other conditions Cirrhosis of liver Unknown

(Include pregnancy within 3 months of death)

Major findings of operation _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. M. Balter

A. M. BALTER, LT. COL., M.C.M. GEN. DIR.

Address Ft. Howard, Md. Date signed 2-14-46

1911

FEB 16 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01424

CERTIFICATE OF DEATH

★ Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
 County.....
Catonaville
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Summit Park Apts.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....md County.....Baltimore
 City or town.....Catonaville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Summit Park Apts.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

ANNIE

Elizabeth Tinker

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife.....James Tinker
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) December 24, 1861
 8. AGE: Years 84 Months 1 Days 27 If less than one day.....hrs.min.

9. Birthplace.....Baltimore
 (Town, county, and state)

10. Usual occupation.....None

11. Industry or business

12. Name.....Sheppard

13. Birthplace.....

14. Maiden name.....Unknown

15. Birthplace.....

16. Informant.....Mr. Sumner

Address.....Summit Park Apts.

17. Burial Date thereof.....Feb. 23, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Landow Park

Location.....Baltimore

18. Funeral director.....George A. Foxley

Address.....Shadybrook - Frederick Ave.

19. 2-22 1946 Harry L. Miller
 (Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 20 1946 at 7:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 28 1945 to Feb 20 1946

and that I last saw him alive on Feb 20 1946

Immediate cause of death.....

Terminal Hypertension

Myocardial Infarction

Due to.....Coronary insufficiency

Due to.....Cardiovascular

degenerative disease

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Eliot W. Johnson

3432 Union Ave M. D. or other

Address..... Date signed.....2-20-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH

County BaltimoreCity or town Glenarm
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Glenarm
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Albert Todd

3. (b) Social Security Number

354-01-64114. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Blanche H. Todd7. Birth date of deceased (mo., day, yr.) July 22-1886 6. (c) If alive, give age _____ years8. AGE: Years 59 Months 6 Days 21 It less than one day _____ hrs. _____ min.9. Birthplace Baltimore Co. Maryland
(Town, county, and state)10. Usual occupation Brickmason

11. Industry or business

12. Name Jermiah R. Todd13. Birthplace Maryland14. Maiden name Martha Beatty15. Birthplace Maryland16. Informant Mrs. Blanche H. ToddAddress Route #1, Glenarm, Md.17. Rural Date of report Feb 16-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary's (Hampden)Location Baltimore, Maryland18. Funeral director Burgess Funeral HomeAddress 3631 Fells Road, Baltimore19. Feb 15 19 46 W. J. W. W. W. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13-1946 at 6:05 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12-1946 to Feb 13, 1946and that I last saw him alive on Feb. 13 19 46Immediate cause of death Cotary thrombosis DURATION 2 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Clifford F. Hudson MD. M. D. or other _____Address Fork, Md. Date signed 2/4/46

Mr. Hudson

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01426 34

1. PLACE OF DEATH:
 County Baltimore
 City or town Uppesee
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Uppesee
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME
Emory Clinton Tracey

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M.
 6. (b) Name of husband or wife Bezie M Tracey
 6. (c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) Feb 17-1860
 8. AGE: Years 85 Months 11 Days 29 It less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Ret. farmer
 11. Industry or business

FATHER
 12. Name Richard C Tracey
 13. Birthplace Maryland
 MOTHER
 14. Maiden name Mary Price
 15. Birthplace Maryland

16. Informant Mrs E C Tracey
 Address Uppesee, Md.
 17. Burial Date thereof Feb 19/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grace
 Location Balto co. Md
 18. Funeral director Edw C Gipton
 Address Hamptstead Md

19. Feb. 17 1946 Cyril E. Fowble M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1946 at 11:57 P. M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Feb. 16 1946 to Feb. 16 1946
 and that I last saw him alive on Feb. 16 1946
 Immediate cause of death Acute Dilatation of Heart
 DURATION Sudden
 Due to Acute indigestion
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Cyril E. Fowble M.D.
 Address Uppesee, Md. Date signed 2/17/46
 M. D. or other

RECEIVED

FEB 19 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63-9

CERTIFICATE OF DEATH

01427

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore Co., Md.City or town Blenheim Road
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore Co.City or town Blenheim
(If outside city or town limits, write RURAL and give nearest town)Street No. Blenheim Rd. R.F.D. No. 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George John Trapp

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Lydia A. Burk Trapp

7. Birth date of

deceased (mo., day, yr.)

Jan. 24, 1854

8.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

92024

hrs.

min.

9. Birthplace

Blenheim Balto. Co., Md.
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name

John George Trapp

13. Birthplace

Germany

MOTHER

14. Maiden name

Magdalena Beck

15. Birthplace

Germany

16. Informant

Mrs. Emma Trapp

Address

Blenheim Rd., Blenheim Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 20, 1946
(month) (day) (year)

Cemetery or crematory

St. John's Lutheran Cemetery

Location

Blenheim Baltimore Co., Md.

18. Funeral director

Elmer W. Coulter & Son

Address

924 E. Eager St.

19.

Feb 19

19

19W. M. D. Registrar

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 19 46, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 13 19 46 to Feb 17 19 46and that I last saw him alive on Feb 16 19 46

Immediate cause of death

Central vascularhemorrhage

DURATION

6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Elizabeth B. Schmitt M.D.

M. D. or other

Address Cockeysville, Md. Date signed Feb 17, 1946

Lockysville

309912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01428

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 10 mos., 21 days
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
 How long in hospital or institution? 0 yrs., 10 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 134 Willard Street
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Elizabeth Wade

3. (b) Social Security Number

213-12-2882

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lloyd O. WadeB.(c) If alive, give age 27 years7. Birth date of deceased (mo., day, yr.) March 18, 1918

8. AGE: Years 27 Months 10 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Adam Miller13. Birthplace Rumania14. Maiden name Susan Schneider15. Birthplace Rumania16. Informant Mrs. Elizabeth WadeAddress 134 Willard St., Balto., Md.17. Burial Burial Date thereof Feb. 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New Cathedral CemeteryLocation 4300 Old Fred. Rd., Balto., Md.18. Funeral director George L. SchwabAddress 2101 Frederick Ave., Balto., Md.19. Feb. 10 1946 Earl T. Webster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 19 46, at 8:50 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20, 19 45, to Feb. 10, 19 46.and that I last saw her alive on February 10, 19 46.Immediate cause of death Pulmonary Tuberculosis DURATION 15 Mos.Due to Tubercle Bacilli

Due to _____

Other conditions Tuberculous Laryngitis 15 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations No operationAutopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other _____Address Mount Wilson, Md. Date signed 2/10/46

Rec'd by Dr. E. E. Nichols

RECEIVED

FEB 13 1946

BUREAU V-6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01429

Reg. Dist. No. 21-44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 119 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
 How long in hospital or institution? 119 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.
 City or town Arnold
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
SAW
 2. (a) If veteran, name war _____

3. (a) FULL NAME

MALICHI NEWBY WARD

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Carrie R. Ward
 6. (c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) 8-24-75
 8. AGE: Years 70 Months 6 Days 12 If less than one day _____ hrs. _____ min.
 9. Birthplace North Carolina
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business _____
 12. Name Andrew Ward
 13. Birthplace North Carolina
 14. Maiden name Mary Newby
 15. Birthplace North Carolina

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Ft. Howard, Maryland
 17. Burial Date thereof Feb 8/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Margaret's Episcopal
 Location St. Margaret's, Maryland
 18. Funeral director B. L. Hopping
 Address Annapolis, Maryland
 19. Feb 8, 46 Capt. F. J. Tolleson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1946 at 11:20P M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1945 to February 6, 1946
 and that I last saw him alive on February 6, 1946
 Immediate cause of death
Disease of the heart
Coronary Arteriosclerosis,
myocardial insufficiency,
Anginal Syndrome
 Due to _____
 Other conditions Hypertension, arterial
Pyelonephritis, chronic
 (Include pregnancy within 3 months of death)

DURATION
8 Mos.
plus

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 Rmc Ann Balter
 23. SIGNATURE A. M. BALTER, LT. COL., M.C. or CHIEF OF BIN. DIR.
 Address Fort Howard, Maryland Date signed 2-7-46

FEB 9 1946
BUREAU V.R.

Cornuty
COPY SENT TO LOCAL REGISTRAR No. DATE 2/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County... BaltimoreCity or town... Kensington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 4215 Kensington Road
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Mary E. Wardell

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

John H. Wardell

7. Birth date of

deceased (mo., day, yr.)

December 12, 1865

6. (c) If alive, give ago... years

8. AGE:

Years

Months

Days

If less than one day

80123

hrs.

min.

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Elias Airey

12. Name

Maryland

13. Birthplace

Sarah Piddicord

14. Maiden name

Maryland

15. Birthplace

Mrs. William H. Powell4215 Kensington Road

Address

BurialDate thereof... 2-7-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Meadowdale Memorial ParkLocation... Howard County, Md.Funeral director... George L. SchwalbAddress... 2101 Frederick Avenue, Balt., Md.19. 2-6 19. 46 Awmedayik

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 4, 1946 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 7, 1943 to Feb 4, 1946and that I last saw him alive on Jan 14, 1946

Immediate cause of death

Acute Myocarditis

Due to

Marked generalized arteriosclerosis

Due to

Other conditions

Auricular fibrillation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Coolahan, M.D.Address... 4261 Wilkens Ave Date signed... 2/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 4 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 6 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)Street No. 1855 N. Collington Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Matilda Weichseldorfer

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife John Weichseldorfer

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 18, 1876

8. AGE: Years Months Days If less than one day

6993

hrs. min.

9. Birthplace Germany
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name John Schrank13. Birthplace Germany14. Maiden name Mary Maria15. Birthplace Germany16. Informant Hospital RecordsAddress Catonsville 28, Maryland17. Burial Date thereof 2-23rd, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Belair Road18. Funeral director Leo S. HookAddress 1701-03 N. Patterson Park Ave19. 2-22 19 46 Harry J. Kuller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 19 46 at 10:55 a.m.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
August 17, 1945 19 45 to February 21 19 46
and that I last saw him/her alive on February 21 19 46Immediate cause of death Terminal Broncho-pneumonia DURATION 3 daysDue to Acute myocardial insufficiency 4 daysDue to Chronic arteriosclerotic cardio-vascular disease. Indef.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk M. D. or otherAddress Catonsville 28, Md. Date signed 2/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED

FEB 25 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. George S. Kieffer
2470 Washington Blvd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01432

Reg. Dist. No. 137

1. PLACE OF DEATH:

County Catonsville

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Burka Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2907 Northern Parkway
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Sarah Agnes Wertz

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife Emmanuel H. Wertz

7. Birth date of deceased (mo., day, yr.) May 5th, 1856

8. AGE: Years 89 Months 8 Days 30 If less than one day
hrs. min.

9. Birthplace Abbottstown, Pa.
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Solomon Maul

13. Birthplace Pa.

14. Maiden name ?

15. Birthplace ?

16. Informant Mr. Ira N. Wertz

Address Hillendale, Silver Springs, Md.

17. Burial Date thereof 2-6-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Abbottstown, Pa.

18. Funeral director Leonard J. Ruck

Address 5305 Harford Road

19. Feb. 6 19 46 Harris H. Miller
(Date rec'd by registrar) (month) (day) (year) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4th, 19 46 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Acute cardiac failure

Due to Cardiovascular disease

Due to sudden death

Other conditions lung

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. G. S. Kieffer Rep. Med.

M. D. or other

Address 1010 Leeds Ave Date signed 2-4-46

RECEIVED BY THE SECRETARY OF THE ARMY

STANDARD HEADLINE

1946

13

RECEIVED
FEB 8 1946
3-READ V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH:

County Baltimore
 City or town Uppesee Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Balto
 City or town Uppesee Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Washington Irvine Wheeler

3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Hester J Wheeler

7. Birth date of deceased (mo., day, yr.)

Feb 11-1898

6.(c) If alive, give age

68

years

8. AGE:

Years

Months

Days

If less than one day

68

-

17

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Ret farmer

11. Industry or business

FATHER

12. Name

Wm W Wheeler

13. Birthplace

Md

MOTHER

14. Maiden name

Elizabeth J Amason

15. Birthplace

Md

16. Informant

W Leslie Wheeler

Address

Hampstead Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

Mar 2/46

(month) (day) (year)

Cemetery or crematory

Grace

Location

Baltimore Md

18. Funeral director

Edw Gipton

Address

Hampstead Md

19.

(Date rec'd by registrar)

1946

April E. Fowle M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 28 1946 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1941 to Feb 28 1946
 and that I last saw him alive on Feb 28 1946

Immediate cause of death

Acute Pulmonary
Oedema

DURATION

45 min

Due to

Acute left ventricular
failure

1 hr.

Due to

Hypertensive
Cardiovascular Disease

15 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury

Injured at work?

23. SIGNATURE

Maurice C. Portenfield

M. D. of other

Address

Hampstead Md

Date signed 2/28/46

RECEIVED
MAR 2 1945
BUREAU. P. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

CERTIFICATE OF DEATH

Reg. Dist. No. 25

01434

1. PLACE OF DEATH:
 County 203 Hillcrest Ave
 City or town Brooklyn Hts. Balt 25 Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md County A. A. County
 City or town Brooklyn Hts. Balt 25 Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 203 Hillcrest Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Edna O. Williams

3. (b) Social Security Number
302-09-5419

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Russell G. Williams
 6. (c) If alive, give age 47 years
 7. Birth date of deceased (mo., day, yr.) April 4th 1889
 8. AGE: Years 56 Months - Days - If less than one day hrs. min.

9. Birthplace East Palestine Ohio
 (Town, county, and state)
 10. Usual occupation Book Binder & Housewife
 11. Industry or business Ohio State University
 12. Name William C. Owens
 13. Birthplace Unknown
 14. Maiden name Edna P. Owens
 15. Birthplace Ohio

16. Informant Mrs. G. Zonak
 Address 203 Hillcrest Ave
 17. Burial Date thereof Feb 16 - 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Glen Haven Memorial Cemetery
 Location Gov. Ritchie Highway, Glenburnie Md
 18. Funeral director Wilton Schilling
 Address 3914 S. Hanover St - 25 -
 19. 2-15-46 (Date rec'd by registrar) Unwedged Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13th 1946 at 7:50 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 1946 to February 13 1946
 and that I last saw him alive on 19
 Immediate cause of death Coronary Occlusion DURATION 2 1/2 hrs.
 Due to Atherosclerosis & Hypertension 1 yr.
 Due to Chronic Myocarditis 1 yr.
 Other conditions Chronic Myocarditis
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. None

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of None
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE P. J. Jannaldi M.D. M. D. or other None
 Address 4609 Gov. Ritchie Hwy Date signed 2-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K3-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Parkville
(If outside city or town limits, write RURAL and give nearest town)Street No. 7811 Clarksworth Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Margaret L. Wisenauer

3.(b) Social Security Number

4. Sex 30 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife John A Wisenauer

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 11 19158. AGE: Years 30 Months 7 Days 2 It less than one day _____ hrs. _____ min.9. Birthplace State Michigan
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Glenn H Perkins13. Birthplace Michigan14. Maiden name Greta Clark15. Birthplace Michigan16. Informant John A WisenauerAddress 7811 Clarksworth Place17. Burial Date thereof 2/16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Glen Haven CemeteryLocation Anne Arundel County18. Funeral director Leachman Funeral HomeAddress 7401 Belair Road19. Feb. 14 19 46 Mrs. A. L. Reiskinder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 19 46 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Carbon Monoxide Poisoning

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 2-13-46Where did injury occur? NONE
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. B. Davis M.D.Address 1111 N. E. Avenue, Baltimore, Md. Date signed 2/13/46

FEB 30 1946

BUREAU V. E.